should immediately notify the NF DON or administrator of the individual's refusal, and the NF should counsel the individual or representative on the consequences of refusal.

Any termination of the PASRR Level II assessment must be clearly documented in the case record. PASRR/MI cases will use the "Inappropriate Referral" form and submit it to either the IPAS agency or State PASRR Unit, as appropriate.

When an IPAS case is terminated after referral for Level II has been made:
a) the IPAS agency should immediately notify the CMHC or D&E Team of the case status; and
b) the Level II assessment should also be terminated at the point notice is received from the IPAS agency; and
c) whatever documentation has been completed will be retained in the file.

12.1.6 NF Retention of Level I and Level II

Federal regulations require that:
a) the NF receive a copy of any applicable Level I screen, with the certification of for need for Level II at the bottom; and/or
b) the Level II assessment with all supporting documentation; and
c) the PASRR Letter/Certificate of Determination; and
d) retain them on each resident's chart;

12.1.7 Transfer of Level I and Level II With Resident

Resident transfers, with or without an intervening hospital stay, require transfer of the most current Level I and Level II assessment documentation to the new, admitting NF.

It is the responsibility of:
a) the prior NF to provide copies of these assessments to the new NF; and
b) the new or admitting NF to request and review these assessments as part of the admission, MDS, and care planning processes.

12.1.8 Time Limit Level II Determination Is Effective

The PASRR Level II assessment and findings are effective until there is a substantial change in the applicant's or resident's:
a) MI mental health condition; or
b) MR/DD functioning status or medical condition.

- For PAS-MI, however, the IPAS assessment and determination finding is:
  a) only effective for ninety (90) days from the date of the PAS 4B Notice of Determination; and
  b) must be updated or redone when an individual is not admitted to a NF within ninety (90) days of the PAS 4B issuance. (See Chapter 5.5.)

- For PAS-MR/DD, the Level II assessment and determination are effective for one (I) year, unless there has been a substantial change in functioning status or medical condition.

When the ninety (90) days has expired, the applicant or NF will contact the IPAS agency to update or complete a new IPAS assessment and finding. For PASRR cases, the IPAS agency will:
a) review whether there has been a significant change in mental and/or MR/DD condition;
b) if no change, the IPAS agency will document its finding; and
   1) indicate that the information contained in the Level II is current to the individual's condition on page 1 of the MI Level II; and
   2) resubmit the case record for a PASRR determination; but
c) if there is a change, the IPAS agency will provide the information to the CMHC or D&E Team, which will decide:
   1) whether a new Level II should be completed; or
   2) whether sections of the Level II should be updated; or
   3) that another Level II is not needed and whether to:

PASRR

i) issue an Inappropriate Referral form or letter/statement; or
ii) have the IPAS agency update the original PASRR/MI Level II assessment by certifying, "No change" or "Remains Same," with the reviewer's initials, affiliation, and date of certification prominently entered at the top of the first page.

When a new Level II is required, the IPAS agency will make a clear notation on page 1 of the new Level II showing that this is a reassessment and the reason for it.

- For RR, the Level II assessment and determination remain effective until the individual, MI and/or MR/DD, has a significant change in mental status and/or MR/DD condition. (Also see Chapter 14 of this Manual.)

12.2 APPEALS, RECONSIDERATIONS, AND JUDICIAL REVIEW

An individual has the right to:
a) "appeal" an adverse action and request a fair hearing when he/she disagrees with the PASRR determination; and/or
b) request a "reconsideration" of an adverse finding when there is documentation pertinent to the reason for the denial which was not previously submitted.

Reconsideration using additional documentation follows a process similar to that for the original decision and can be processed more quickly than an appeal. An appeal, however, is a separate, formal process which usually requires more time. An appeal reviews whether the determination was correct based on the documentation submitted.

12.2.1 Reconsideration

An individual may request "reconsideration" of an adverse finding:
a) using pertinent case documentation, not previously submitted, provided after the final determination;
b) submitted by the applicant or the NF and/or attending physician acting on behalf of the individual;
c) requested as soon as the additional documentation is identified, but no later than within thirty (30) days of the effective date of the determination.

When there is documentation, it may be advisable to request both an appeal and reconsideration at the same time, due to the 30-day time constraint for filing an appeal request. Reconsideration does not replace the appeals process, but may enhance it.

When reconsideration upholds the original adverse finding, an appeal will already be in process and time is not lost. If, however, the reconsideration reverses the original determination, the Hearing and Appeals Section will be notified to cancel the appeal.

Reconsideration is requested:
a) for MI: through the IPAS agency for need for NF level of services (Level of Care) issues; and
b) for MR/DD: through the BDDS Field Office for issues involving specialized services;
c) by resubmitting:
   1) the entire original IPAS case record;
   2) with new documentation clearly flagged;
   3) to the State PASRR Unit;
d) clearly marked as a "Request for IPAS/PASRR Determination Reconsideration."

12.2.2 Appeals

Information on filing an appeal is printed on all determination notices for PAS and RR:
a) for PAS, it is on both the front and back of the PAS 4B form (Appendix P); and
b) for RR, it is in the body of the RR Determination Letters (Appendix HH).

The appeal request will be submitted within thirty (30) days of the date of the determination notice.

An appeal is requested:

a) by sending a letter:
   1) with the individual's signature;
   2) to the Indiana Family and Social Services Administration, Division of Family and Children, Hearings and Appeals, 402 W. Washington Street, Room W-392, Indianapolis, Indiana 46204;
b) containing:
   1) the individual's address and a telephone number where he or she can be contacted; and
   2) a copy of the notice with the adverse action being appealed.

If the individual is unable to write the letter him/herself, someone may provide assistance in requesting the appeal.

The Division of Family and Children will notify the individual and the IPAS agency which issued the determination in writing of the date, time, and place for the hearing. When the individual has been admitted to a NF in another IPAS agency's area, the IPAS agency with the case record will forward it to the NF's local IPAS agency for representation at the hearing.

Prior to, or at the hearing, the individual or his representative has the right to examine the entire contents of the case record.

12.2.3 Representation At Appeal Hearings

The individual may represent him/herself at the hearing or authorize a representative such as an attorney, a relative, a friend, or other spokesman to do so. At the hearing, there is a full opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments without interference, and question and refute any testimony or evidence presented.

For PAS:

a) the IPAS Agency which has the complete case file will provide case documentation, clarification, and evidence needed upon request of the State PASRR program for preparation of testimony for PASRR appeal hearings; or
b) if the applicant has entered a NF in another IPAS agency's catchment area:
   1) the original IPAS agency will forward a copy of all case documents to the NF's local IPAS agency; and
   2) the second IPAS agency will provide representation at the hearing;
c) the local OFC Office will act as agent of the Medicaid program representing the PASRR finding at the hearing and
d) OMPP, the State PASRR program, the BDDS Field Office and/or the D&E Team may also provide written testimony for the appeal hearing.

For RR:

a) the local OFC Office will act as agent of the Medicaid program representing the State PASRR determination at the hearing;
b) additional documentation or information may be presented to the State PASRR program:
   1) by the CMHC for support or clarification of the PASRR/MI determination; and
   2) by the D&E Team to address the PASRR/MR/DD determination.

12.2.4 Judicial Review

After exhausting all administrative remedies, the individual may obtain judicial review. Information on how to obtain judicial review will be provided to the individual as part of the appeal determination notice.

12.3 CASE RECORDS

12.3.1 Availability of Level II to Physicians, Hospitals, and Individuals

The PASRR Level II assessment and determination are available to the applicant's or resident's attending physician, the discharging hospital for an individual who has been hospitalized, and the applicant or resident, the guardian or health care representative.

Release of PASRR Level II assessments and notices of determination to attending physicians and staff of discharging hospitals is authorized under Federal Regulations 42 CFR 483.128(l) and 42 CFR 483.130(k). A separate release of information from the patient is not required for pertinent requests.

- Attending Physician: An "attending" physician is considered to be that physician who has primary responsibility for the medical care of the individual.
- Discharging Hospital: The "discharging" hospital is that hospital which provided acute inpatient care and in which the individual currently resides or from which he or she was recently discharged.

Following State review and determination, the complete PASRR Level II case is sent:
a) to the NF for review and retention on the resident's NF chart for individual's admitted to a NF; and
b) to the IPAS agency or BDDS Field Office which processed the Level II case for individuals who are not admitted to a NF.

These documents are available to the attending physician and discharging hospital for review and/or copying, upon request
a) at the admitting NF; or
b) for individuals who are not admitted to a NF, at the IPAS Agency or BDDS Field Services Office which processed the Level II case.

The NF has the responsibility to:
a) make the Level II evaluation and determination part of the Resident Assessment/Minimum Data Set (RA/MDS) and care planning/case conferencing process; and
b) provide the Level II evaluation and determination information to the individual or resident and his or her legal representative for RR.

For PAS, the IPAS agency will provide to the individual or resident and his or her legal representative this information with a copy of the Level II case materials, as appropriate, with the results of the PASRR Level II assessment and determination.

12.3.2 Confidentiality of Case Records

All authorized entities with access to IPAS/PASRR case records must maintain confidentiality following all pertinent state and federal laws and regulations.

12.3.3 Disposition of Case Records

At the conclusion of the PASRR determination, the appropriate entity must assure that the entire case record packet on which the PASRR determination is based is sent to the appropriate NF.

When the case record is faxed, the State PASRR Unit will send only a copy of the final determination:
a) PAS 4B form, to the appropriate IPAS Agency; and
b) RR determination letter, to the CMHC or D&E Team/ for RR;
for inclusion in the agencies' case file. The D&E Team will forward a copy to the BDDS Field Office.

NOTE: The State PASRR Unit does not retain a copy of the case record. The IPAS agency, CMHC, or D&E Team/BDDS Field Office keeps a copy on file.

For YRR or situations where the original case documents are mailed instead of faxed to the State PASRR Unit, the State PASRR Unit will:
a) fax the determination to the IPAS agency, CMHC or D&E Team; and
b) directly mail the original case record to the indicated NF.

Upon receipt of the determination, the local agency will:
a) put the determination with the case record;
b) make a copy for the agency's file; and
c) send the entire case record to the applicable NF.

The NF must assure that:

a) the case record and determination are retained on the client's active chart; and
b) if the resident transfers to another NF, a copy of the entire Level II case record is provided to the new NF prior to, but no later than, the time of NF transfer.

The receiving NF must review all pertinent documents addressing a resident's condition, including the PASRR Level II, when determining whether the NF can meet the patient's needs.

12.3.4 Retention of Case Records

The IPAS Agency, CMHC, BDDS Field Office and D&E Team must retain legible copies of all case documents pertinent to the PAS and/or RR portions for which they are responsible for a period of at least three (3) years from the date of most recent case action. For all PASRR cases, the signature date of the designated determination authority will be the determination date. (Also see Chapter 5.8.)

If a reconsideration or appeal is processed, the most recent signature date of the designated determination authority will be used.

This documentation provides support for future audit purposes. Copies of these materials must be made available to OMPP, the State PASRR Unit, and state or federal surveyors or auditors upon request. As needed, copies of case documentation must be available for appeal hearings or audit purposes.

CHAPTER 13
"PAS" PORTION OF PASRR

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- Definition
- Process

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- Definition
- Process

13.7 PAS/PASRR TIMELINESS REQUIREMENT

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CHAPTER 13
"PAS" PORTION OF PASRR

PAS is the process used for new admissions only. (Transfers and readmissions are part of the RR process.) "New admission" also includes those situations wherein an individual is discharged from a NF to a community living arrangement and later needs to be readmitted to a NF.

NOTE: To avoid confusion with the "PAS" part of PASRR, Indiana's PreAdmission Screening program is referred to as "IPAS" throughout this Manual.

13.1 ADMISSION REQUIREMENTS

Effective January I, I989, federal regulations prohibit NFs participating in Medicaid from admitting or retaining any individual with mental illness and/or mental retardation/developmental disability who:

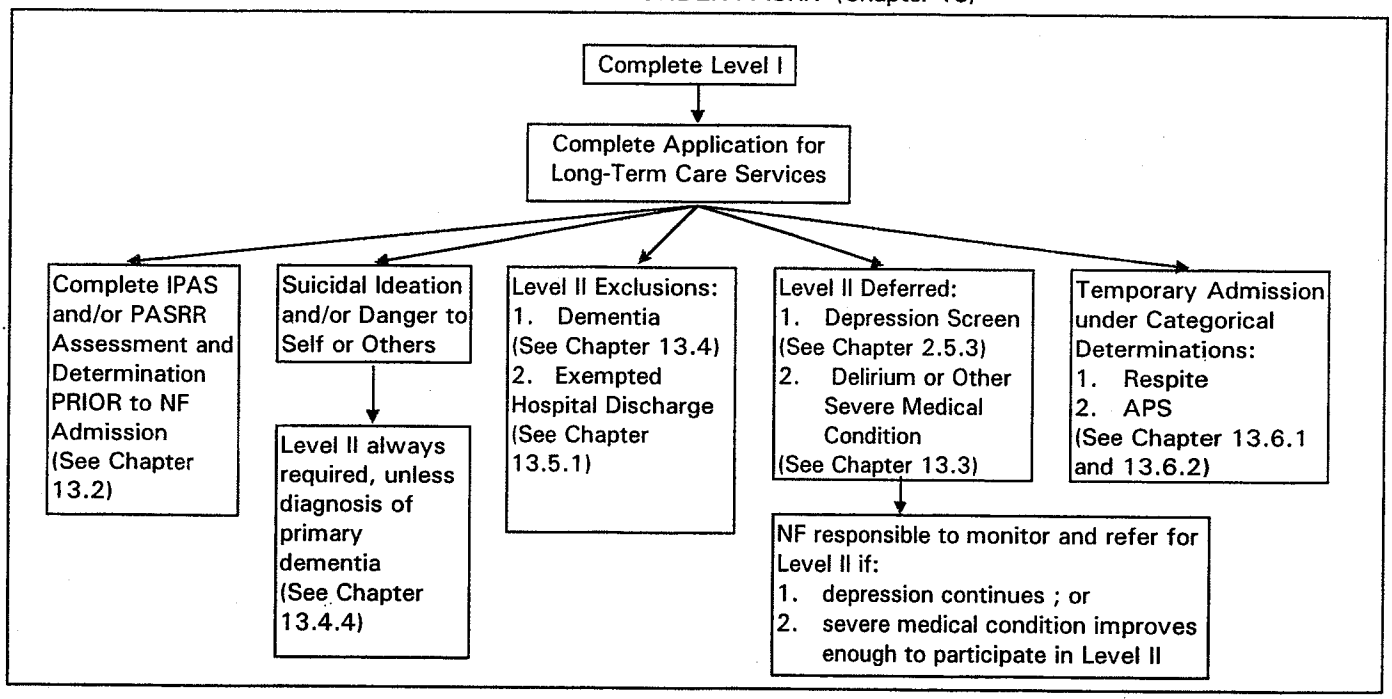
a) should have been assessed under PASRR, but was not; or
b) was assessed and determined to be inappropriate for NF placement.

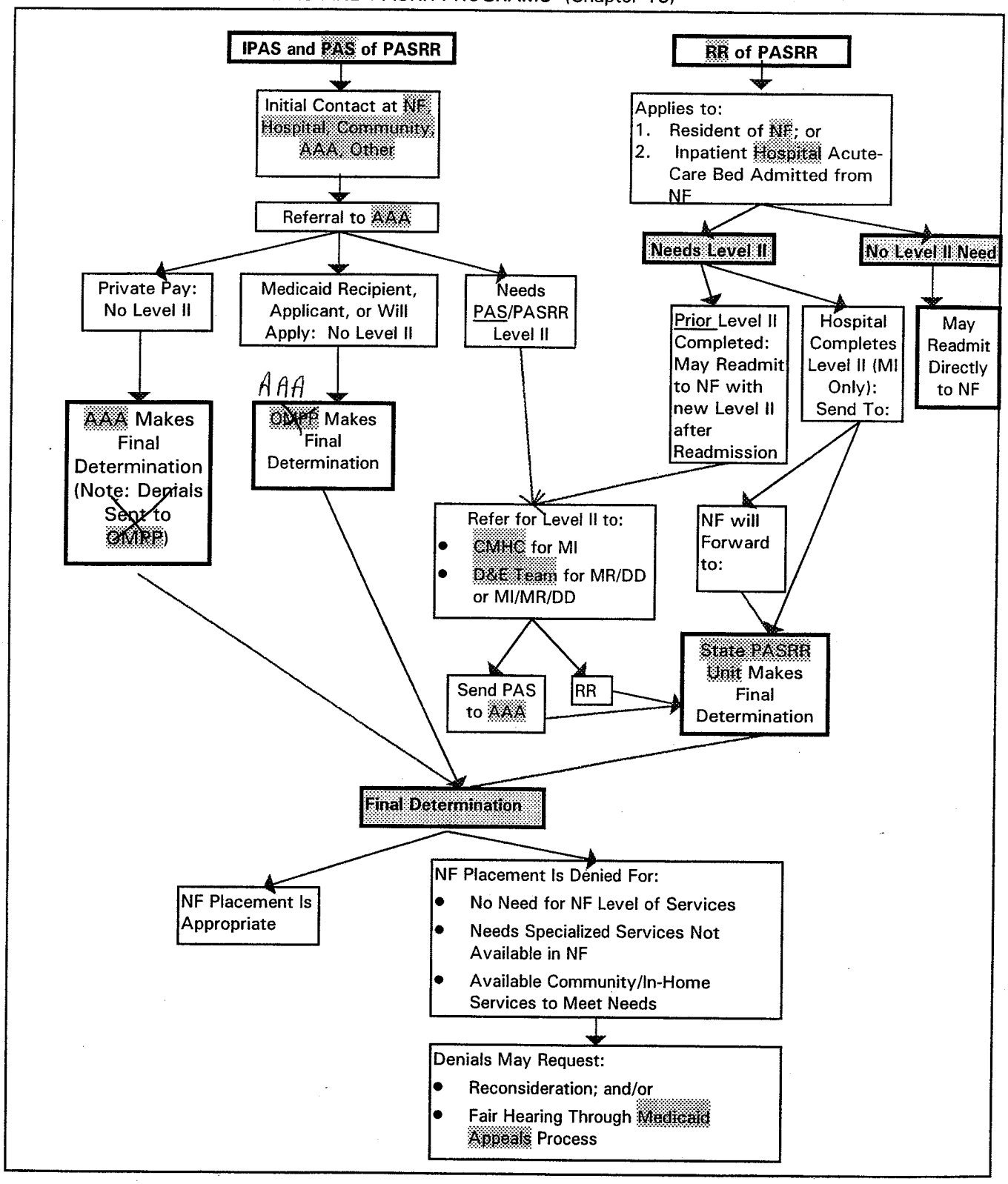
Indiana's PAS program provides part of the PASRR Level II assessment. Individuals may be admitted to a NF when:

a) IPAS program requirements including the PASRR Level II assessment and determination are completed PRIOR to NF admission; or
b) the applicant qualifies under one of the conditions listed in this Chapter for temporary admission, pending completion of the PASRR Level II process.

Planning for NF admission should begin as soon as possible to allow as much time as possible for the necessary screenings and assessments. In particular, hospital units must identify and prepare those individuals who are at risk of NF placement early in the inpatient stay. To wait until discharge is imminent is to risk delay of discharge and placement.

TYPES OF ADMISSION UNDER PASRR (Chapter 13)





13.2 LEVEL I: IDENTIFICATION SCREEN

A Medicaid-certified NF is prohibited from admitting any new resident without completion of the PASRR Level I: Identification Screen PRIOR to admission. (See Appendix U.)

NOTE: EVERY completed Application for Long-Term Care Services form (PAS Application form) must have an appropriately completed Level I form attached prior to submission to the PAS Agency.

13.2.1 Level I: Purpose and Completion

The Level I: Identification Screen consists of eight (8) questions designed to identify whether an applicant has, or is suspected of having, a condition of MI and/or MR/DD. All eight questions should be carefully read and answered.

The Level I form is used as:

a) the primary identifier of need for Level II assessment;
b) the certification of temporary NF admission under Exempted Hospital Discharge (middle of the form); and
c) the Certification of Need for Level II (bottom of the form).

The Level I may be completed by any professional individual who:

a) has sufficient knowledge of the applicant and his condition to be able to answer the eight questions;
b) will sign the Level I screening form, giving title/position and the date of completion; and
c) will check the box beneath the signature which designates the person's position.

If a hospital discharge planner or NF staff member completes the Level I, the name of the hospital or NF with which the person is affiliated should be entered.

The Level I Decision-Making Protocol (see Appendix F) and the Screen for Depression (see Appendix V) are tools to provide guidance in making this decision.

the Level I should be completed PRIOR to application for IPAS In order to decide whether an applicant can refuse to participate in IPAS. If the Level II is required, the applicant must NOT check "refuse to participate" on the LTC application form and be admitted to a Medicaid-certified NF, even under the PAS penalty.

13.2.2 Other Indicators

The following identifiers of need for Level II assessment may also apply:

a) recent suicidal and/or homicidal ideation; and/or
b) recent or current residence in a state psychiatric hospital or MR/DD facility (including Indiana or any other state), regardless of known diagnosis (including dementia); and/or
c) currently receiving services from a CMHC for a serious mental illness (MI) condition, as defined by the PASRR/MI program, or from a provider of MR/DD services; and/or
d) other documentation, such as a hospital discharge summary, 450B form, etc.

Information may either supplement or contradict the information on the Level I. The IPAS agency should:

a) investigate and reconcile any discrepancies;
b) note the findings on the Level I form and explain it in the case record; and
c) immediately initiate the Level II assessment.

Whenever the IPAS agency decides that Level II is or is not required contrary to responses on the Level I, the reason must be clearly and thoroughly documented in the case record.

NOTE: At any point that it is identified that an individual requires PASRR Level II assessment but has not had one, regardless of the responses on the Level I or prior findings (such as a prior PAS 4B), the PASRR Level II assessment must be completed. (Also see Chapter 12.)

13.2.3 Certification of Need for Level II

For all new admissions the IPAS agency, acting as an entity independent of the NF, must:

a) review EVERY completed Level I form;
b) determine the need for further assessment under Level II;
c) certify the need for Level II assessment with either "yes" or "no" that Level II is or is not needed;

13.2.4 Notice To Applicant/Resident

First time positive results which indicate a need for Level II require written notice to the applicant, or his or her legal representative that referral will be made for Level II assessment.

For PAS, the IPAS agency will issue a written notice that:

a) the applicant has been identified as having, or is suspected of having, a condition of MI and/or MR/DD; and
b) is being referred to the State MI or MR/DD authority for Level II assessment. (See Appendix X.) for the format to be used.)

For RR, the NF will provide the written notice to a resident (who has been identified for the first time for a referral for Level II assessment), his/her legal guardian and/or legal representative, that:

a) the resident has been identified for Level II assessment based on a suspected condition of MI and/or MR/DD; and
b) is being referred to the State MI or MR/DD authority.

13.2.5 Referral for Level II Assessment

Level II Mental Health Assessment is completed by the:

a) Community Mental Health Center (CMHC) for individuals with a MI condition; and
b) Diagnostic and Evaluation (D&E) Team for individuals with:
    1) a condition of MR/DD; or
    2) a dual diagnosis of MI and MR/DD (MI/MR/DD). See Chapter 13.2.1.

Referral for Level II is made:

a) for PAS, by the local IPAS Agency to the CMHC or D&E Team, as appropriate; or
b) for RR, by the NF directly to the CMHC or D&E Team for Significant-Change RR. See Chapter 12.

For residents of a State psychiatric hospital, the responsible staff person of the hospital will:

a) coordinate the proposed transfer to a NF with the designated gatekeeper CMHC;
b) obtain a letter from the gatekeeper CMHC stating whether there is concurrence with the proposed NF transfer;
c) initiate contact with the IPAS agency with the request for IPAS assessment, including:
    1) the name, address, and other information on the appropriate gatekeeper CMHC; and
    2) the following completed forms or certifications:
        i) Level I form;
        ii) Application for Long-Term care Services;
        iii) Certification letter by the designated CMHC gatekeeper; and
        iv) Form 450B Sections I-III, Physician Certification of Need for Long-Term Care Services.

The IPAS agency serving the area of the hospital will make referral for PASRR/MI Level II assessment to the designated CMHC gatekeeper. Also see Chapters 10.5.5.

13.2.6 PAS Assessment Termination Prior to PASRR/MI Level II Referral

When PAS determines that an applicant with MI:

a) does not to meet the need for NF services criteria; and
b) State PASRR Unit, after conferring with the IPAS agency, concurs;

the PAS/PASRR process may be terminated prior to CMHC Level II referral.

When submitting a PAS case packet to the State PASRR office for the denial determination, the reason for non-referral for PASRR/MI Level II must be clearly documented on the PAS 4A form or in a cover letter.

NOTE: This does not apply for individuals with a condition of MR/DD and/or MI/MR/DD. Also, RR Level II **must be completed and a determination made under both NF LOC and Level II assessment.**

13.2.7 Routing and Retention of Level I

After completion, the Level I form will be routed as follows:

a) for PAS, the NF or entity completing the Level I must:
   1) attached the Level I form to the Application form and other required documentation;
   2) immediately send a copy of the Level I together with the PAS Application to the PAS Agency which serves its area; and
   3) retain a copy, with the Application form, on the resident's chart.

NOTE: The Level I and PAS Application must be sent to the PAS Agency for all applicants, including those who do not agree to participate and do not require Level II, but who are admitted to the NF under PAS penalty, within five (5) days of completion.

b) for RR, the NF is no longer required to complete Level I form, but may voluntarily use it as a tool to identify residents with MI.

NOTE: RR referral is now based on the MDS for Significant-Change RR or on CMHC or D&E Team tracking for YRR. See Chapter 12.

For transfers between NFs, the transferring NF must provide a copy of the Level I and Application forms to the receiving NF.

13.3 LEVEL II DEFERRAL DUE TO MEDICAL CONDITION(S)

Level II assessment may be deferred:

a) when an individual is unable to participate due to a condition of severe medical illness (such as delirium, a comatose state, recent traumatic head injury);
b) which makes it impossible for the individual to participate actively in the Level II.

The PASRR Level II will only be deferred until the individual's condition improves enough for a Level II to be completed.

13.3.1 PAS Cases

For PAS cases, the IPAS agency:

a) will gather sufficient information and/or documentation to ascertain that a severe medical condition described above applies;
b) immediately contact the CMHC or BDDS Office to review pertinent information and receive a concurrence of whether the Level II may be deferred;
c) record a narrative explanation in the case record; and
d) specify the decision on the PAS 4A prior to submission of the case to the State PASRR Unit final determination.

13.3.2 RR Cases

For RR cases, the CMHC or BDDS Office will:

a) gather sufficient information and/or documentation to decide whether Level II should be deferred; and
b) if the Level II should be deferred, the finding will be recorded on the Inappropriate Referral form prior to submission to the State PASRR/MI Unit.

13.3.3 State PASRR Unit Action

The State PASRR Unit will:

a) enter the decision on the PAS 4B or the PASRR RR Determination; and
b) include a caveat stating the NF's responsibility to:
   1) monitor the individual's condition; and
   2) make a referral for Level II when the individual's condition sufficiently improves.

13.4 PASRR/MI DEMENTIA EXCLUSION

The PASRR/MI Dementia Exclusion only applies when an individual;

a) would require Level II due to a condition of serious MI; but
b) has a condition of dementia (including Alzheimer's Disease and related conditions) which is of a degree of severity which is primary over the serious MI; and
c) does NOT have any condition of MR/DD.

NOTE: It is important to understand that the Dementia Exclusion can only be applied to PASRR/MI. Persons who are MR/DD or dually diagnosed as MI/MR/DD do not qualify for this exclusion and must be assessed under Level II.

In order to apply the Dementia Exclusion, the evaluator must:
a) consider all applicable diagnoses of the individual (not limited to those diagnoses specific to a particular crisis or hospitalization);
b) differentiate the level of severity of the dementia and that of the MI condition; and
c) ascertain which is primary/principle.

Generally, levels of dementia are divided into "mild, moderate, and severe." A mild dementia, for example, would not supersede a condition of schizophrenia whereas a severe dementia may be found to be primary over the schizophrenia.

NOTE: For PASRR program purposes, "diagnosis" refers to the individual's overall mental and physical condition. Ranking of diagnoses as primary/principle, secondary, and so forth should be made in this context. Listings of diagnoses must be current to the date of the documentation. The "date of onset" will help establish the rank of a conditions or diagnosis.

13.4.1 Level I Form and Dementia Exclusion

To apply the Dementia Exclusion, Question #1 on the Level I must be answered accurately. (See Appendices F and U.) Question #1 is actually a three-part question:
a) "Does the individual have a documentable diagnosis of senile or presenile dementia (including Alzheimer's Disease or related disorder) based on criteria in DSM-III-R [or current DSM]..."
b) "...without a concurrent primary diagnosis of a major mental illness or..."
c) "...[without] a diagnosis of mental retardation or developmental disability?" (Words in brackets were added for clarification.)

Question #1 can only be checked "Yes" when all three conditions are met.

The following criteria then applies:
a) Question #1 is "Yes" and all other answers are "No:" neither Level II or dementia documentation are required; or
b) **Question #1 is "Yes" and any Question #2-#5 is also "Yes:" the dementia exclusion applies and Level II is not required and the NF must document the dementia. (See Appendix for the Dementia Assessment Checklist form.)**
c)

CAUTION: Do not answer "Yes" for Question #I when there is also a diagnosis of mental illness which is primary/principal over the diagnosis of dementia.

13.4.2 Dementia Documentation

When the dementia exclusion applies:
a) PASRR/MI Level II must not be completed; and
b) the NF must document the diagnosis of dementia on the NF active chart.

The content of the dementia documentation must be sufficient to:
a) reduce or eliminate the possibility of a misdiagnosis of dementia resulting from a confusion between mental illness and dementia; AND
b) assure that conditions which mimic dementia have been considered and ruled out; AND
c) provide reasonable evidence of the dementia condition.

NOTE: FOR FEDERAL PASRR PURPOSES, THE PHYSICIAN'S SIGNATURE WITH THE DIAGNOSIS ALONE IS NOT ENOUGH TO DOCUMENT THE DEMENTIA DIAGNOSIS.

Dementia documentation should:
a) apply dementia criteria of the current DSM;
b) be based on a good mental status examination;
c) identify the type of testing or assessment done;
d) specify the date of the testing and/or assessment;

e) include a good physical and history;
f) rule out other conditions which may mimic dementia or cause treatable dementia;
g) summarize the results, including a stated conclusion;
h) have a dated signature and the affiliation of the person who performed the assessment; and
i) be dated and signed by the individual's physician.

The "Dementia Assessment Checklist" form (see Appendix Y) is an optional form developed to assist NFs with the dementia documentation requirement. Sections #1 through #5 include areas which need to be addressed, at a minimum, in any documentation of dementia.

Other forms of documentation may be used instead, including, but not limited to, the following:
a) the findings of a thorough mental status examination focusing especially on cognitive functioning, supported by a thorough history and physical examination;
b) physician's examination and written medical history established over a long period of time showing progressive deterioration, that dementia is the most likely diagnosis, and that other conditions which may mimic dementia have been considered and ruled out.; (A complete and identifiable summary of the record which addresses these facts would suffice.)
c) although not sufficient by themselves, the interpretation of the results of other testing such as CT Scan, EEG, MRI, etc. may be included and must reflect the organicity of the condition and show dementia; or
d) only as a last resort, when it is unclear whether MI or dementia is predominant, may a Level II assessment be done.

NOTE: When Level II is done, it must be reviewed and certified by the State PASRR Unit before it can be used to admit an individual or as an exclusion from future Level II assessment.

13.4.3 Use and Retention of Dementia Documentation

Do not refer for Level II to document dementia. Whenever applicable, the Dementia Exclusion must be used. It is the responsibility of the NF to:
a) obtain the documentation;
b) retain it on the resident's chart; and
c) provide a copy of it:
   1) when state or federal auditors request it; and
   2) to a new NF when the resident transfers.

Unless the dementia is a temporary condition and has improved, all future Level I screenings for the resident should reflect the dementia exclusion. The NF should write on each Level I: "Dementia documentation attached," or "...in chart," or "...on file," etc. The NF should clearly tag or mark the dementia documentation for easy identification during audits.

13.4.4 Suicidal Ideation and/or Danger to Self or Others

Only individuals who qualify under the dementia exclusion are excluded from the Level II assessment requirement when there is a threat of suicidal ideation and/or danger to self or others. It is the responsibility of the NF to review and understand the individual's needs and to ascertain whether the NF can meet those needs without danger to the resident, other NF residents and NF staff.

However, when the IPAS agency is aware that suicidal ideation or threats may exist, it should:
a) enter a caveat in the section of the Application form certifying authorization for temporary admission; and
b) enter the caveat on the PAS Forms 4A and 4B, to document and alert the NF that:
   "Applicant's behavior of (specify behavior) may present danger to self and/or others. The admitting NF must assure the safety of the applicant, all other residents, and the NF staff."

13.5 TEMPORARY NF ADMISSION

An individual may be admitted for a short, temporary stay in the NF under:
a) the "Exempted Hospital Discharge" provision; or
b) one of the two (2) determination categories listed below for "Respite Care" and "Adult Protective Services."

NOTE: The only "emergency" admission under PASRR is use of the APS Categorical Determination.

b) one of the two (2) determination categories listed below for "Respite Care" and "Adult Protective Services."

NOTE: The only "emergency" admission under PASRR is use of the APS Categorical Determination.

The IPAS agency must assure that the case record and PAS 4A form clearly describes:
a) the type of PASRR categorical determination or hospital exemption used for admission, including applicable dates;
b) requests for extension of an approved temporary authorization, including the reason for extension and the applicable time period;
c) requests for a change of an approved temporary period to a long-term placement, including the change in condition or other reason that permanent placement is now needed and applicable extension dates, when appropriate;
d) changes in status from IPAS-Only to PASRR, including circumstances and type of temporary authorization originally given; and
e) admissions without temporary placement authorization or final determination which have incurred an IPAS Class A infraction.

The appropriate form(s) must be enclosed and the dates of authorized temporary admission clearly shown.

Since available short-term authorizations may not be sufficient to meet the individual's needs, but long-term placement is not needed or sought, the IPAS agency can complete the assessment requesting approval for the anticipated additional time needed. An approval for placement may be requested, for example, for an additional 3-months, 6-months or other identified limit.

13.5.1 Exclusion: "Exempted Hospital Discharge"

PASRR does not allow the IPAS-Only category of "Direct from Hospital" admission. The only allowable NF admission from a hospital acute care bed prior to completion of full PASRR Level II assessment and determination is via the "Exempted Hospital Discharge" provision.

- Definition

An individual may be exempted PASRR Level II for NF admission if the following conditions are met:
a) NF admission directly follows medical treatment in an acute-care non-psychiatric hospital bed; and
b) NF services are needed for the same condition for which the individual received acute hospital care; and
c) less than 30 days of NF care is required, as certified by the attending physician.

NOTE: Not all convalescent care stays from hospitals will be able to fit the prerequisite of less than 30 days duration to recuperate. For those persons, the complete Level II assessment must be completed PRIOR to NF admission. Federal interpretative guidelines give the example of a hip fracture which would normally need more than 30 days to improve and warn NFs to be careful of such admissions.

Medicaid will not reimburse for inappropriate use of the "Exempted Hospital Discharge" exclusion. Such inappropriate use will be noted on the PASRR final determination form.

- Process

PASRR Level I form, Section V - Part A (Appendix S) is used to record the "Exempted Hospital Discharge." The following criteria apply:
a) Section IV of the Level I must be completed;
b) Section V must be completed and signed by the physician, prior to NF admission;
c) the Application for Long-Term Care Services (Appendix L) must be completed (either at the hospital or admitting NF) and attached to the Level I;
d) the NF must retain a copy; and
e) both completed forms must be immediately sent to the IPAS agency.

The NF should also determine the presenting reason for the hospital stay and record it on the Level I form.

The PAS Agency must:
a) review the information;
b) certify the need for Level II referral on the bottom of the Level I; and
c) provide a copy of the certified Level I to the NF for its records and submission to OMPP when Medicaid reimbursement approval is sought.

13.5.2 Longer Stay Requested

When a longer stay is required for convalescence, the NF must:
a) make a referral for a PASRR Level II before the expiration of the 30-day period;
b) send a written explanation of the reason for continued stay directly to the PAS Agency clearly explaining:
   1) the reason the continued stay is needed including why the person did not convalesce within the expected time frame; AND
   2) the anticipated length of additional time needed (e.g.: 30 days, 60 days, long-term placement).

The IPAS agency must:
a) include the letter in the PAS case record;
b) clearly record on the PAS Form 4A the original admission dates and the extension date;
c) provide a copy of the extension to the NF and applicant; and
d) complete the full IPAS/PASRR assessment in sufficient time so that the State PASRR Unit can issue the determination within 40 calendar days of the NF admission.

13.6 CATEGORICAL DETERMINATIONS FOR SHORT-TERM STAYS

Indiana's PASRR only allows for two (2) categories of short-term, temporary NF stay:
a) Respite; and
b) APS 7-Day.

Although the names are the same, there are significant differences between the IPAS and the PASRR versions.

It is noted that these are <u>not</u> exclusions from PASRR, but are determinations that certain PASRR requirements for temporary admission are met. PASRR Level II is only delayed. If an individual needs longer NF placement than the authorized time, the Level II must be completed within the specified time frame.

13.6.1 "PASRR Respite"

An individual may be temporarily admitted to a NF:
a) from home;
b) for a short-term respite care stay not to exceed thirty (30) calendar days per quarter;
c) with a break of at least thirty (30) days between stays of fifteen (15) or more consecutive days of respite care; and
d) with an expressed intention of leaving the NF by the expiration of the approved time period.

- **Definition**

Respite care is:
a) defined as a temporary or periodic service provided to a functionally impaired individual for the purpose of relieving the regular caregiver;
b) applies to individuals who:
   1) have a caregiver; and
   2) originate from a non-institutional, community-based setting, including foster care homes.

Respite care is not allowed for persons coming from an institution such as a hospital, NF, large ICF/MR, or small MR/DD group home.

- **Process**

The NF must provide sufficient information for the PAS Agency to make a decision that the applicant qualifies for temporary placement under this provision.

Respite Care stays may:
a) only be authorized by the PAS Agency;
b) PRIOR to the NF admission;
c) on PASRR Form 2A-Section V, Part B (see Appendix W).

The PAS Agency should:
a) send a copy of the PAS Agency's authorization on the appropriate form to the NF to retain on the individual's chart; and
b) issue form PAS 4B, specifying the type of admission and applicable dates.

For Medicaid eligible applicants, the NF will attach a copy of form PAS 4B to it's reimbursement request.

13.6.2 "PASRR APS (7-Day)"

An endangered adult who requires Level II:
- may be admitted temporarily to a NF;
- from home or a non-institutional, community-based setting, including foster care homes (not applicable for persons coming from an institution such as a hospital, NF, large ICF/MR, or small MR/DD group home);
- after being referred to Adult Protective Services (APS) and determined to be an endangered adult under APS guidelines;
- for a period not to exceed seven (7) calendar days while:
  1) the assessment (including the Level II) and determination are made; and/or
  2) alternative living arrangements are made.

NOTE: The only "emergency" admission to a NF under PASRR is under the APS Categorical Determination.

• Definition

An endangered adult is:
* an individual, at least eighteen (18) years of age;
* who is harmed or threatened with harm as a result of neglect, battery or exploitation. (See definition in Appendix B of this Manual.)

• Process

The NF must:
a) must cooperate to provide sufficient information about the individual and the situation for the IPAS Agency to make a determination of whether PASRR APS requirements are met; and
b) immediately send the Level I and Long-Term Care Services Application (PAS Application) to the IPAS Agency.

The IPAS agency:
* is the only entity that can authorize PASRR APS admission;
* will make a decision of whether the applicant qualifies for placement under the APS provision;
* obtain the co-signature of the APS Investigator which attests to the individual's status as an "endangered adult" on PASRR Form 2A, Section V, Part B; (The APS Investigator cannot authorize NF admission.)
* sign PASRR Form 2A, Section V, Part B to authorize temporary admission;
* send a copy to the NF to retain on the individual's chart;
* conduct the entire IPAS/PASRR assessment within seven (7) days of referral; and
* include a copy of the authorization in the PASRR case record submitted to the State.

13.6.3 CCRC 5-Day

The individual using the 5-day stay must be a current resident of the same CCRC in which the transfer is occurring. The Five-Day Transfer Within a CCRC cannot be used for admission of an individual from an outside living arrangement. (See Chapter 3.5.)

- Definition

A Continuing Care Retirement Community (CCRC) is a self-contained, life-care multi-level living arrangement consisting of several settings intended to meet an individual's needs at various stages of life. (See definition in Appendix B, page 3.)

The purpose of this advance categorical determination is to allow medical treatment for a physical illness and/or to determine if hospitalization is necessary for that illness.

- Process

The process for temporary CCRC 5-Day admission will follow the same guidelines and requirements as those for IPAS. (See Chapter 3.5.1 to 3.5.3 for procedures.)

This temporary admission may not be used for the purpose of assessment or treatment of a psychiatric disorder. At the time of admission, there must be an express intent of leaving the NF by the expiration of the approved time period (5-days).

If the stay is to exceed the time period, the NF must, no later than the fifth (5^{th}) day following admission:

a) take an IPAS Application form and Level I;
b) immediately send or fax the completed forms to the local IPAS agency; and
c) follow the IPAS process.

For purposes of PASRR, such referrals shall be considered preadmission screenings (PAS/PASRR).

13.7 PAS/PASRR TIMELINESS REQUIREMENT

Federal regulations require that a PASRR/PAS determination must be made:

a) as quickly as possible; but
b) no later than within an annual average of seven (7) to nine (9) working days of the referral of an individual by the PAS Agency to the CMHC or D&E Team conducting the Level II.

However, it is evident that entities responsible for meeting this requirement must adhere to tighter time frames in order to assure that the annual average is maintained. The following criteria apply:

a) the CMHCs and D&E Teams must complete the assessment for PAS (and Significant-Change RR) as soon as possible, but no later than six (6) working days to allow for submission to the State; and
b) PAS (and Significant-Change RR) cases must be expedited as quickly as possible, particularly for acute care hospitalized individuals, to avoid unnecessary delays resulting in excessive costs.

The FSSA defines working days as days which are based on the annual holiday calendar issued from the Governor's Office, and the work week is defined as Monday through Friday. In calculating average working days, the first day will be the first full working day following referral from the IPAS agency for PAS (or the NF for Significant-Change RR).

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CHAPTER 14
"RR" PORTION OF PASRR

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CHAPTER 14
"RR" PORTION OF PASRR

14.1 GENERAL

Federal regulations require that each resident of a NF with MI and/or MR/DD receive, at a minimum, a Level II RR at each significant change in mental health or MR/DD condition. Indiana's PASRR program also provides for yearly resident review for certain NF residents.

14.1.1 Types Of RR

Resident Review (RR) is an evaluation and determination for NF residents who:

a) are suspected of having mental illness (MI) and/or mental retardation/developmental disability (MR/DD); and
b) have experienced a significant change in MI and/or MR/DD condition (Significant-Change RR); or
c) are identified by the CMHC or D&E Team/BDDS Office for yearly follow-along through a prior Level II assessment (Yearly RR); or
d) are identified as requiring Level II, but whose timely assessment was missed ("Missed RR") as:
    1) "Missed PAS;"
    2) "Missed YRR;" or
    3) "Missed Significant-Change RR.

14.1.2 Determining Need for RR

Need for RR may be identified by:

a) the NF;
b) the hospital;
c) the CMHC or D&E Team/BDDS Office; or
d) the Medicaid NF Audit Review Team.

Need for RR Level II will be based on:

a) a finding of the prior Level II that Yearly RR is required; or
b) a finding that PAS or RR Level II was required, but was never completed; or
c) a significant change in mental health or MR/DD condition identified by the MDS; or
d) a Medicaid NF Audit Team determination that a Level II is needed.

NOTE: The Level I: Identification Screen form is **only used for PAS.** It is **no longer required for RR** Level II. It is optional for NF use to determine need for RR, and may be voluntarily used to identify residents needing Level II assessment.

If the Medicaid NF Audit Team determines that a RR is required in disagreement with a NF's finding, the Medicaid NF Audit Team will:

a) certify its decision, explaining the reason RR is needed on the Audit Worksheet.; and
b) promptly contact the CMHC or D&E Team to do a Level II

The need for RR Level II assessment should be certified by:

a) the CMHC or BDDS Office on page 4 of the Level II: Mental Health Assessment for future Yearly RR assessments; or
b) the NF for significant-change in condition in its referral letter to the CMHC or BDDS Office.

14.1.3 CMHC and D&E Team Action

Upon receipt of a NF referral, the CMHC or D&E Team must:

a) review all submitted materials; and
b) identify what kind of RR is being referred; and

c) make a decision regarding the individual's need for and appropriateness of a Level II assessment.
The CMHC or D&E Team should resolve any questions, inconsistencies, or lack of information in the NF referral by contacting the initiating NF.

The finding may be that:
a) RR Level II is required (YRR, Significant-Change, or "Missed Level II");
b) RR is not required at this time; or
c) RR should be deferred due to a resident's inability to participate in the assessment.

When it is decided that RR is not required or should be deferred:
a) the CMHC will document its decision on an MI: Inappropriate Referral form; or
b) the D&E Team will document it in writing on company letterhead.
The completed MI: Inappropriate Referral form or D&E Team letter will explain the circumstances related to the deferral decision.

Decisions to defer a RR Level II should first consider:
a) the reported seriousness of the individual's mental health or MR/DD condition;
b) need for intervention
c) intensity of anticipated treatment; and
d) provision and efficacy of interim mental health and/or MR/DD services.

When the Level II is deferred, the NF is responsible to monitor the individual's condition and make referral to the CMHC or D&E Team when the individual becomes able to participate in Level II. The D&E Team will inform the BDDS Office.

The CMHC or D&E Team will take action to conduct the necessary Level II assessment and forward it to the State.

PASRR Unit or BDDS Office for final determination within the following time frames.

14.1.4 NF Transfers and Readmissions

Residents who are transferred between NFs, with or without a hospital stay, are subject to RR. Prior to admission, the NF will need to assure that required PAS or RR Level II assessment was completed. As soon as it is determined that:
a) the PAS was missed in that an individual has been a NF resident for more than one (1) year; and/or
b) the PAS 4B has already been issued;
c) the "Missed PAS" requires a RR Level II.

14.1.4.1 Transfers

An "interfacility transfer" occurs when an individual is transferred from one NF to another NF, with or without an intervening hospital stay.

PRIOR to transfer, the admitting NF should:
a) ensure that timely PAS and/or PASRR assessment was completed, if required, in the discharging NF;
b) obtain a copy of applicable and available documentation, including but not limited to:
   1) the last Level I form and Application;
   2) most recent Level II;
   3) current medical information, certified Form 450B (Physician's Certification), nurse's notes and the most recent MDS; and

c) preview all documents, including the Level II, for use in care planning for the transferring resident and to assure that it accepts only those individuals whose needs the NF can meet; and
d) review all records to ascertain whether the Level II is current, i.e., whether a significant change occurred in mental health or MR/DD condition and the required Level II for this change in condition was completed.

The discharging NF must:
a) send to the new (admitting) NF originals or copies of the resident's documentation, as applicable and available:
   1) most recent Level I and Application;
   2) most recent certified Form 450B, Physician's Certification;
   3) most recent PAS or RR Level II and MDS reports;
   4) PAS Form 4B; and
   5) current medical information, including nurses' notes; and
b) if there has been a change in condition which requires a RR, complete a new Significant-Change RR PRIOR to the transfer.

Following admission, the new NF will ascertain:
a) if Yearly RR is required:
1) as noted in the service recommendations portion (page 4) of the MI Level II or on the MR/DD Certification; and
2) if needed, notify the local CMHC or D&E Team/BDDS Office of each transfer from another NF who requires Yearly RR; and/or
b) if Significant-Change RR was needed:
1) but not completed; and
2) notify the local CMHC or D&E Team and submit the necessary documents for Level II to be completed.

Need for Yearly RR should be noted on the resident's chart and flagged for quick reference for requests from the Medicaid NF Audit Review Team.

14.1.4.2 Readmissions from Hospital

An individual is a "readmission" if he or she:
a) has been receiving continuous medical care in a NF prior to hospitalization; and
b) is readmitted to a NF (the same or a different NF) from a hospital to which he or she was transferred for the purpose of receiving care.

There is no limit to the type or length of hospital stay. (For purposes of IPAS and PASRR, the Medicaid 15-day bed-hold is not applicable.)

Under PASRR, an individual's readmission to the same or a different NF depends on:
a) the type of care provided in the acute care hospital bed; and
b) if PASRR Level II is needed, whether a current Level II exists for the individual.

NOTE: A PASRR Level II is considered "current" until the individual has a significant change in mental health or MR/DD condition, as applicable.

14.1.4.2.1 Prior PAS or RR Level II

Prior to discharge to the NF, the hospital discharge planner will need to:
a) identify if the individual has been hospitalized for inpatient psychiatric care (in a designated psychiatric unit or other inpatient bed); and

b) coordinate with the NF from which the individual was admitted to determine if the individual has a current Level II.

When there is a current Level II, the NF may directly readmit the individual and have the new Significant-Change RR Level II completed after readmission.

Prior to but no later than at the time of readmission, the hospital must provide a letter of assurance with the following documentation to the NF:
a) the patient is stable and not a danger to him/herself or others; and
b) information on the mental health services the individual needs after NF readmission.
This information must be retained in the resident's active record at the NF in lieu of a new Significant-Change RR, replaced by the RR Level II done following the readmission.

After the individual has been readmitted, the NF will promptly:
a) notify the CMHC or D&E Team/BDDS Office of need for a Significant-Change RR; and
b) send a copy of the hospital's letter of assurance with other referral documentation to the CMHC or D&E Team.

NOTE: If Yearly RR falls due during a hospital stay for medical only care, the NF will notify the CMHC or D&E Team as soon as the resident is readmitted. The Level II will be performed within the required quarter or no later than the quarter immediately following readmission to a NF.

14.1.4.2.2 No Prior PAS or RR Level II

The NF must not readmit the individual until a PASRR determination has been rendered.

When the hospital determines that the individual:
a) does NOT have a current Level II;
b) but has had a significant change in mental health or MR/DD condition; and
c) requires a Significant-Change RR Level II:
the Significant-Change RR must be completed PRIOR to readmission to a NF.

NOTE: For MI, the Level II may be completed by either the CMHC or the hospital in which the resident is an inpatient. For MR/DD, it must be completed by the D&E Team.

When a hospital completes the PASRR/MI Level II: Mental Health Assessment for an inpatient, PRIOR to readmission of the resident it will:
a) obtain a new Form 450B, Physician Certification; and
b) prepare a FAX packet with a FAX cover sheet clearly noting that the Level II is for Significant-Change: and
c) FAX the cover letter, Level II, new Form 450B, discharge summary and other pertinent documentation to the State PASRR Unit for determination.
The MI Level II will be processed as follows:
a) the State PASRR Unit will promptly issue a PASRR determination letter/certificate to the identified hospital; and
b) the hospital must provide to the selected NF (no later than at admission):
    1) the case documents which were FAXed to the State PASRR Unit, including the original MI Level II; and
    2) the FAX copy of the PASRR determination letter/certificate.

14.1.5 RR Level II Assessment

See Chapter 13 for information about the PASRR Level II assessment form and process.

In addition, the RR Level II assessor should always:

- include a face-to-face interview with the resident; and
- review the resident's MDS, pertinent chart documentation, and available materials from other sources which pertain to the Level II assessment.

When a hospital completes the PASRR/MI Level II assessment for a patient in an acute care bed, it should also coordinate the assessment with information from the NF and the most recent MDS, whenever possible.

The RR is an interactive process with the NF's assessment and care planning system in which the MDS and Level II assessment complement each other. The hospital, CMHC and D&E Teams will:

a) utilize documentation and information found in the current MDS;
b) confer with the NF staff as necessary concerning areas of discrepancy or inaccuracy; and
c) respond to and resolve questions from the resident, responsible person, and NF.

NOTE: The CMHC or D&E Team will conduct the mental health or DD portion of the Level II assessment to the point that necessary findings can be made. When applicable, the CMHC will use the Inappropriate Referral form to document why a complete MI Level II assessment was not done. The D&E Team will document its findings on its letterhead.

The D&E Team must notify the BDDS Office when the referral is received.

The NF must:

a) utilize the findings of the RR in its care planning and service provision for each resident; and
b) share questions which arise concerning a resident's MI and/or MR/DD condition and functioning in consultation with the Level II assessor(s).

14.2 "SIGNIFICANT-CHANGE IN CONDITION" RR

Federal regulations require a NF to monitor each resident's condition and, when there is a significant change in MI or MR/DD condition, make a referral to the CMHC or D&E Team for a new Level II assessment. The following procedures apply to "Significant-Change" RR assessments.

14.2.1 Identification of Significant-Change

For residents with MI and/or MR/DD conditions, the NF must:

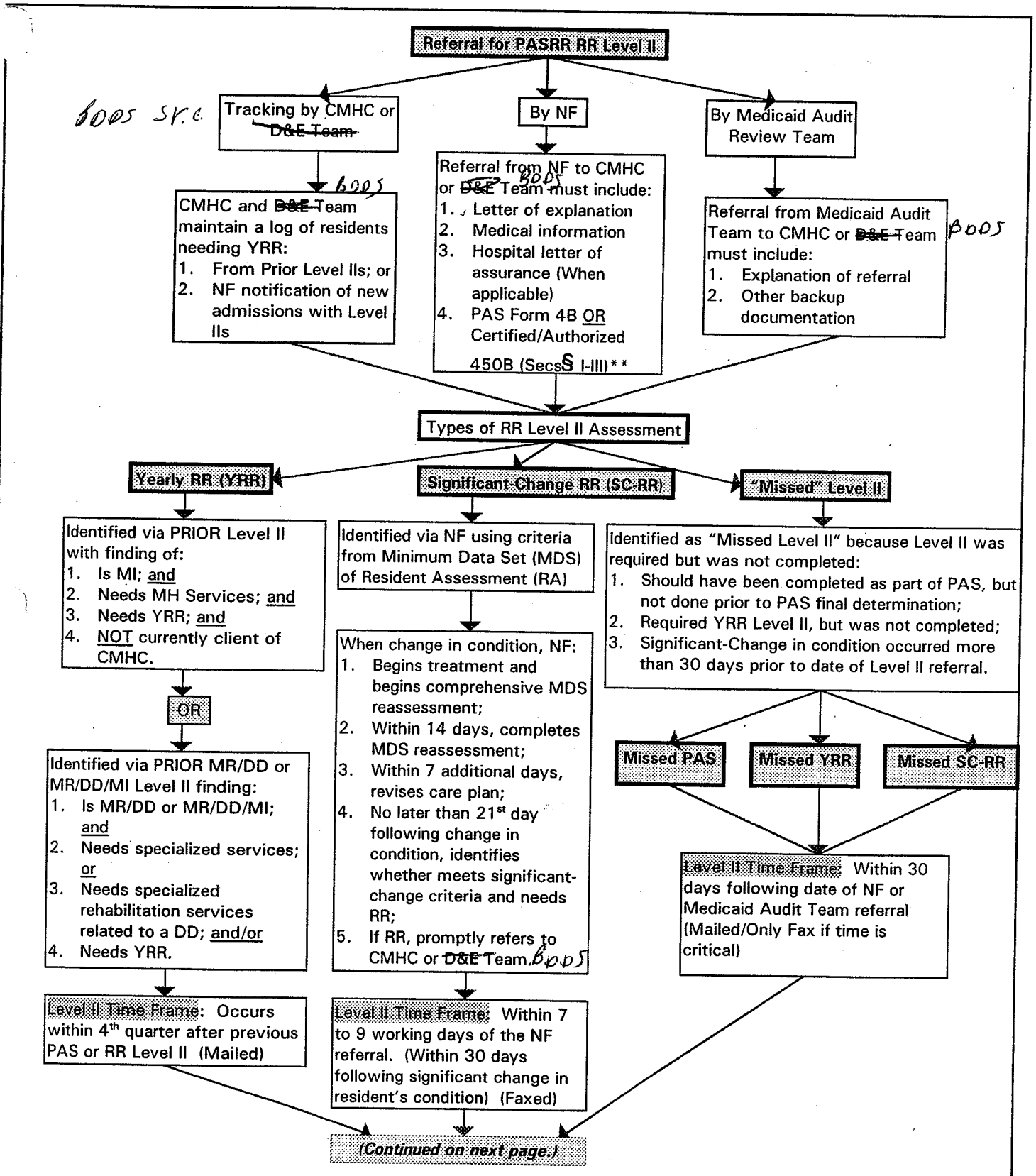
a) monitor each resident's condition; and
b) determine whether, based on "significant change in condition" criteria defined in the MDS, there has been a significant change in the resident's condition which would have a bearing on his or her mental health or overall MR/DD functioning needs; and
c) make necessary referrals for Significant-Change RR.

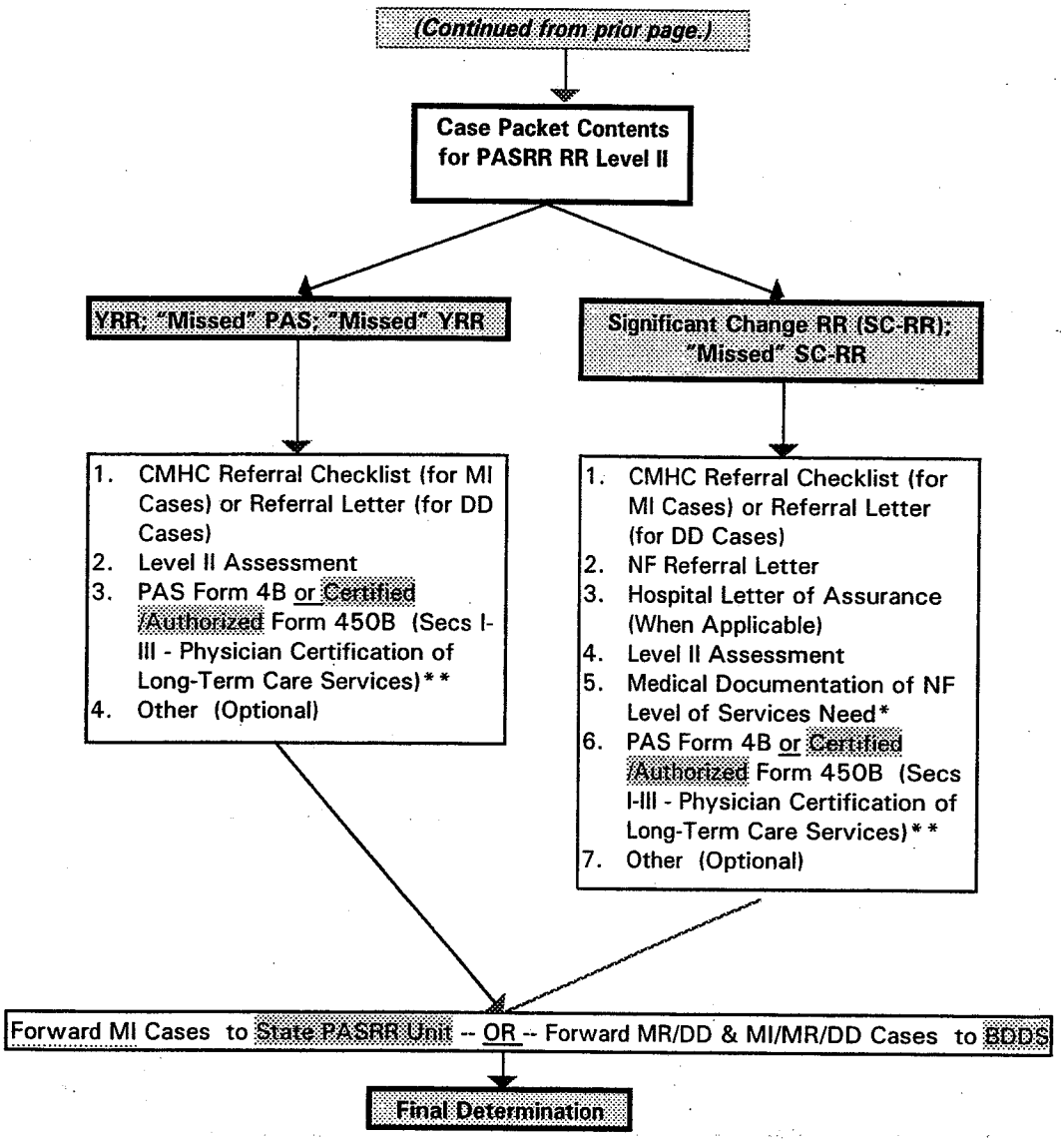
NOTE: When a Level II assessment was required but not completed, it is the responsibility of the NF to make referral for "Missed RR."

14.2.2 Referral for Significant-Change RR

The NF must:

a) make referral for Significant-Change RR Level II to:
   1) the local CMHC for residents with MI conditions; or
   2) the D&E Team for residents with MR/DD;
b) within the time frames of Chapter12.2.3.


Referral for PASRR RR Level II
Tracking by CMHC or ~~D&E Team~~
By NF
By Medicaid Audit Review Team
CMHC and ~~D&E~~ Team maintain a log of residents needing YRR:
1. From Prior Level IIs; or
2. NF notification of new admissions with Level IIs
Referral from NF to CMHC or ~~D&E~~ Team must include:
1. Letter of explanation
2. Medical information
3. Hospital letter of assurance (When applicable)
4. PAS Form 4B OR Certified/Authorized 450B (Secs I-III)**
Referral from Medicaid Audit Team to CMHC or ~~D&E~~ Team must include:
1. Explanation of referral
2. Other backup documentation
Types of RR Level II Assessment
Yearly RR (YRR)
Significant-Change RR (SC-RR)
"Missed" Level II
Identified via PRIOR Level II with finding of:
1. Is MI; and
2. Needs MH Services; and
3. Needs YRR; and
4. NOT currently client of CMHC.
OR
Identified via PRIOR MR/DD or MR/DD/MI Level II finding:
1. Is MR/DD or MR/DD/MI; and
2. Needs specialized services; or
3. Needs specialized rehabilitation services related to a DD; and/or
4. Needs YRR.
Level II Time Frame: Occurs within 4th quarter after previous PAS or RR Level II (Mailed)
Identified via NF using criteria from Minimum Data Set (MDS) of Resident Assessment (RA)
When change in condition, NF:
1. Begins treatment and begins comprehensive MDS reassessment;
2. Within 14 days, completes MDS reassessment;
3. Within 7 additional days, revises care plan;
4. No later than 21st day following change in condition, identifies whether meets significant-change criteria and needs RR;
5. If RR, promptly refers to CMHC or ~~D&E~~ Team.
Level II Time Frame: Within 7 to 9 working days of the NF referral. (Within 30 days following significant change in resident's condition) (Faxed)
Identified as "Missed Level II" because Level II was required but was not completed:
1. Should have been completed as part of PAS, but not done prior to PAS final determination;
2. Required YRR Level II, but was not completed;
3. Significant-Change in condition occurred more than 30 days prior to date of Level II referral.
Missed PAS
Missed YRR
Missed SC-RR
Level II Time Frame: Within 30 days following date of NF or Medicaid Audit Team referral (Mailed/Only Fax if time is critical)
(Continued on next page.)



* NF must provide documentation to show NF Level of Services need. Documentation may be on a new (non-certified/non-authorized) Form 450B, Secs I-III; OR a prior certified Form 450B with additional information attached; OR nurses notes; etc.

The CMHC or D&E Team is not required to make a judgment on the adequacy or appropriateness of documentation submitted by the NF. When insufficient, the State PASRR Unit will get additional information directly from the NF.

** A case may contain two (2) Forms 450B (Secs I-III): ① a non-certified/non-authorized form to establish NF Level of-Services need; and ② a certified/authorized form to establish IPAS compliance.

a) no later than the 21st day following the change in condition, the NF must identify whether the change meets the criteria for a "significant change in condition" and requires a RR; and

b) if a RR is needed, the NF must promptly make a referral to the appropriate CMHC or D&E Team. The D&E Team must inform the BDDS Office.

"Promptly" means that the action must begin immediately.

NOTE: When inpatient psychiatric care is needed, the NF should not wait for these time limits to obtain care or services for the resident. Inpatient psychiatric care should be provided as soon as it is identified that it is needed.

The significant change in condition may or may not require hospitalization. (If the resident is hospitalized, but does not have a current PAS or RR Level II assessment, the RR must be completed and a determination made prior to readmission. See Chapter 12.1.4.)

NOTE: The NF should never delay provision of necessary services, including inpatient psychiatric care, pending PAS or RR Level II assessment. When there is a significant change in condition, the NF should promptly contact the CMHC or D&E Team or another appropriate service provider for the resident.

"Promptly" means that the action must begin immediately within the guidelines of Chapter 12.3.5.

14.2.3 MDS Time Limits for NF

MDS criteria sets specific time limits for the NF to identify whether there has been a "significant change in physical or mental condition." The NF may make referral for Significant-Change RR sooner than this time frame; but it should not be later.

Following the time frames given below, the NF should make Significant-Change RR referral no later than 21 days following the change:

c) when there is a change in condition, the NF must begin treatment to meet the resident's immediate needs and begin a comprehensive MDS reassessment;
d) within 14 days of the change, the NF must complete the MDS reassessment;
e) within 7 additional days, the NF must revise the resident's care plan based on the comprehensive reassessment;

14.2.4 Referral Process for Significant-Change RR

The NF will:

a) promptly initiate the RR referral directly to the CMHC or D&E Team, as appropriate;
b) in writing, including the following:
   1) a letter from the NF explaining the change in condition which requires significant-change RR (when more than one resident is referred at a time, prepare a separate letter and packet for each resident);
   2) documentation to establish medical level of services need, which may include but is not limited to:
      i) a copy of the most recent MDS; and/or
      ii) a new Form 450B, Physician's Certification for Long-Term Care Services; and/or
      iii) a prior certified Form 450B, Physician's Certification, plus additional information; and/or
      iv) applicable nurses' notes; and/or
      v) other appropriate documentation as determined by the NF; and

      for residents readmitted following discharge from hospitalization for a change in mental health or MR/DD condition, a copy of the hospital's letter of assurance to the NF.

      NOTE: The CMHC or D&E Team is not required to make a judgment on the adequacy or appropriateness of documentation submitted by the NF. When insufficient, the State PASRR Unit will get additional information directly from the NF.

NOTE: A NF Audit Team Worksheet, Form 450B, MDS, or other documentation are considered to be "current" when they reflect the resident's condition at the time of the Level II.

For accountability purposes, it is recommended that the NF should:
a) retain a copy of the referral letter to the CMHC or D&E Team; and
b) follow-up with a telephone call to assure that the referral was received and directed to the appropriate individual within the CMHC or D&E Team.

This process applies to all residents who have experienced a significant change in condition, whether hospitalized or remaining in the NF.

14.2.5 Time Limits for Significant-Change RR

The full RR assessment and determination must be completed within applicable time frames, calculated as follows:
a) the NF must notify the CMHC or D&E Team of the need for a significant change resident review within 21 days of the significant change in condition (See Chapter 12.2.); and
b) the full RR Level II assessment from the date of referral from the NF to the final determination from the State PASRR Unit must be completed within an annual average of 7 to 9 working days of the NF referral.

Thus, the RR will be completed within 30 days following the actual significant change in the resident's condition.

14.2.5.1 CMHC and State PASRR Unit Time Limits

The CMHC will:
a) complete the Level II assessment as soon as possible; and
b) submit the Significant-Change RR packet to the State PASRR Unit as soon as possible;
c) but no later than four (4) working days from the date of referral by the NF.

To expedite processing to meet time limits:
a) the CMHC may FAX a copy of the case packet to the State PASRR Unit; and
b) the State PASRR Unit will issue the PASRR RR Determination Letter by return FAX to the CMHC.

The CMHC will:
a) make a copy of the determination Letter for its file; and
b) attach the original to the case packet, and forward the entire case to the appropriate NF for the resident's chart.

The State PASRR Unit will review the packet and issue the Level II determination as soon as possible, but no later than one (1) working day from the date of receipt.

14.2.5.2 D&E Team and BDDS Office Time Limits

The D&E Team will:
a) complete the Level II assessment as soon as possible; and
b) submit the Significant-Change RR packet to the BDDS Office as soon as possible;
c) but no later than four (4) working days from the date of referral by the NF.

The BDDS Office will review the packet and issue the Level II determination as soon as possible, but no later than one (1) working day from the date of receipt.

The BDDS Office will coordinate its action with the State PASRR Unit as required.

14.3 "MISSED LEVEL II" RR

Regulations specify that a Medicaid-certified NF must not admit or retain an individual who requires Level II, but has not been assessed and a determination made. Therefore, at any time that a missed Level II is identified, the Level II must be completed or the individual can no longer remain in a Medicaid-Certified NF.

A "Missed Level II" denotes a situation in which a Level II was required but was not completed in a timely manner. A "Missed Level II" may be for:

a) "PAS:"
   1) required Level II was not completed; or
   2) deferred Level II should have been triggered as a RR within a specified time following admission to a NF, but was not; or
a) "Yearly RR:" a YRR was not done; or
b) "Significant-Change RR:" a change in condition occurred more than thirty (30) days prior to the date referral should have been made by the NF.

"Missed Level II" may be identified and referred for assessment by:

a) the NF;
b) the Medicaid NF Audit Team;
c) the State OMPP or State PASRR Unit; or
d) the CMHC or D&E Team/BDDS Office.

"Missed Level II" assessments will:

a) follow the procedures for Significant-Change RR; except that
b) the Level II must be completed no later than 30 calendar days following the date of NF or Medicaid NF Audit Team referral.

14.4 "YEARLY" RR

Need for Yearly RR (YRR) assessments will be identified as a result of a prior PAS or Significant-Change RR or current YRR Level II. The CMHC or D&E Team will schedule YRR assessments throughout the year.

For each resident who had a PASRR Level II assessment, a NF should always:

a) determine whether the resident will require a Yearly RR as indicated on:
   1) for MI, page 4 of the Level II: PASRR/MI Mental Health Assessment (see Appendix Z) will be checked whether YRR is needed; and
   2) for MR/DD, the Pre-Admission Screening/Resident Review Certification for Nursing Facility Services form (see Appendix CC); and
b) promptly notify the local CMHC or D&E Team/BDDS Field Office of new admissions which transfer from another NF who need Yearly RR.

14.4.1 YRR: Purpose

In addition to the purposes of the Level II assessment discussed in Chapter 13, the purpose of the YRR is to ascertain and document:

a) whether the resident is receiving identified and needed mental health and/or MR/DD services;
b) why a resident, identified as needing mental health and/or MR/DD services but not receiving them, is not provided these services;
c) changes in required mental health and/or MR/DD services; and
d) whether the resident will continue to require Yearly Resident Review.

14.4.2 YRR for MI Residents

a) Residents who require YRR are those who have previously been assessed under PAS and/or RR Level II and found:
b) to be MI; and
a) to need mental health services; and
b) to NOT currently be under treatment or monitoring by an Indiana CMHC and have not been previously reviewed to assure that:
    1) an appropriate plan of care has been developed and followed; and
    2) necessary mental health services are provided; and
d) by the State or State contractors (i.e., CMHCs) to require Yearly Resident Review.

NOTE: For YRR NF residents who are current CMHC clients, the CMHCs should:
a) continue tracking;
b) but not complete YRR unless the CMHC is notified that the resident has had a significant change in condition.

14.4.3 YRR for MR/DD and MR/DD/MI Residents

Residents who require YRR are those who have previously been assessed under PAS and/or RR Level II and determined:
a) to be MR/DD or MR/DD/MI and require specialized services; or
b) to be MR/DD or MR/DD/MI and require specialized rehabilitation services related to a developmental disability; or
c) by the State or State contractors (i.e., D&E Teams) to require Yearly Resident Review.

14.4.4 Recording YRR Decision

At each PAS and RR Level II assessment, the CMHC or D&E Team/BDDS Office will identify residents needing YRR follow-along as part of the service(s) findings.

This determination will be recorded in the services identification section of the Level II assessment. The appropriate box should be checked or a short notation entered stating, "Yearly RR Required."

14.4.5 Tracking YRR

TRACKING: It is the responsibility of each CMHC and D&E Team/BDDS Office to maintain a log and tracking system for:
a) those NF residents in its geographic area who require Yearly RR review; and
b) (for CMHCs) those NF residents in other geographic areas for whom the CMHC is the gatekeeper.

NOTIFICATIONS: In order to track residents needing YRR, the following notifications will need to occur:
a) each IPAS agency will:
    1) send to the CMHC (for MI) or D&E Team (for MR/DD/MI) a copy of the form PAS 4B of PAS Level II assessments; and
    2) if the NF designation on the PAS 4B is "Undecided," notify the CMHC or D&E Team of the NF's name and address when the IPAS agency determines the specific NF to which the IPAS case packet should be sent; and
b) each NF must:
    1) identify admissions and transferred residents who need YRR; and
    2) notify the local CMHC or D&E Team of transfers from other NFs (directly or via the hospital) who need YRR.

The D&E Team will notify the BDDS Office of the transfer.

The names of individuals determined to need YRR shall be added to the tracking log of the CMHC or D&E Team/BDDS Office. (And the CMHC or D&E Team/BDDS Office will delete from its log the name of a resident who has left its catchment area, unless the CMHC is the gatekeeper.)

For MI, the CMHC will:

a) maintain a log and tracking system for Yearly RR;
b) conduct Level II assessments, determine the mental illness diagnosis and the need for mental health services and Yearly RR;
c) compile a Level II case packet for submission to the State PASRR Unit; and
d) confer and coordinate with the NF on the needs of residents who require RR.

For PASRR/MR/DD or MR/DD/MI, the D&E Team will:

e) maintain a tracking system and log of individuals who require yearly resident review;
f) notify the local BDDS Field Office that:
    1) a RR due to a significant change has been requested; or
    2) a yearly resident review is due;
g) conduct the MR/DD Level II assessment; and
h) submit the case packet to the local BDDS Field Services Office.

NOTE: For NF transfers:

a) the first NF must promptly provide a copy of the last Level II assessment, certified Form 450B (Physician Certification), form PAS 4B, and Level II determination to the second NF; and
b) the receiving NF should provide a copy of the Level II to the local CMHC or D&E Team when the Level II was completed:
    1) by a hospital; or
    2) by a CMHC or D&E Team from another area.

14.4.6 Timeliness for YRR

As a general guideline, "Yearly" is defined as occurring within every fourth quarter after the previous PAS or RR Level II. "Calendar quarter" is defined as one of the time periods consisting of:

1st Quarter: January 1 through March 31
2nd Quarter: April 1 through June 30
3rd Quarter: July 1 through September 30
4th Quarter: October 1 through December 31

Since YRRs are a state and not a federal requirement, CMHCs and D&E Team should set up a general schedule for each NF in its area for YRR, spreading the NF YRR reviews throughout the year. Once this is established, the above guideline should be adhered to as much as possible.

NOTE: A YRR may be earlier, but should not be later, than the end of the quarter in which the anniversary date of the previous PAS or RR Level II falls. (For example, if the last Level II assessment applicable signature date is April 15, 1993, then the next Level II assessment is due no later than June 30, 1994.)

As YRR will no longer be linked to an annual NF visit by the Medicaid Audit Review Team, yearly assessments will occur when necessary throughout the year. However, to reduce costs, every attempt should be made to batch together Level IIs by NF. Logs maintained by the CMHC and D&E Teams will track due dates.

NOTE: Significant-Change RRs mandated by federal regulations should always receive first priority. YRRs may be slightly delayed for completion of Significant-Change RRs. When delay for YRR occurs, the CMHC or D&E Team should briefly explain circumstances on the Level II.

14.4.6.1 Level II Effective Date

The effective date of the YRR Level II is:

a) the psychiatrist's signature date on the most recent MI Level II assessment; or
b) the most recent signature date on the DD Level II assessment.

This date becomes the applicable anniversary date to determine the quarter in which the next Yearly RR is due.

14.4.6.2 "Missed YRR" Level II

A required YRR may be "missed" and should be completed as soon as possible, but no later than 30 days following referral or discovery that it was missed. (See Chapter 12.4)

14.5 ACTION WHEN SERVICES NOT PROVIDED

At each Level II assessment, the CMHC and D&E Team assessor will:
a) review the resident's chart, prior Level II, and other documentation during the completion of the YRR; and
b) determine whether identified mental health and/or MR/DD services were provided for the resident.

The Medicaid NF Audit Team will also:
a) review the resident's records and most recent Level II during its audit activities; and
b) determine whether the NF includes identified mental health and/or MR/DD service needs in the plan of care and providing, or making provision for, identified mental health and/or MR/DD services.

When the finding is that services were not provided and there is not an acceptable reason to explain why not, the following action will be taken, as appropriate:
a) MI mental health services:
    1) the CMHC or Medicaid NF Audit Team will confer with the NF to ascertain why services were not provided; and
    2) the CMHC or Medicaid NF Audit Team will document its findings; and
    3) make a referral to the Long-Term Care Services Division of the Indiana Department of Health for follow-up;
b) MR/DD and MR/DD/MI services:
    1) the D&E Team or the Medicaid NF Audit Team will document its findings; and
    2) notify the BDDS Office and the Indiana Department of Health, Long-Term Care Services Division for follow-up.

14.6 MEDICAID NF AUDIT TEAM FINDINGS AND PASRR RR

Under RR procedures, a PASRR Level II Mental Health Assessment or MR/DD assessment is considered "current" until there is a significant change in a resident's mental or MR/DD condition, regardless of the length of time since it was completed.

A determination of need for NF level of services by the Medicaid NF Audit Team includes the "current" PASRR Level II Mental Health Assessment or MR/DD/MI assessment. A new PASRR Level II: Mental Health Assessment or MR/DD/MI assessment are only needed if the resident's mental or DD condition significantly changed and a new assessment was not requested or a required Yearly RR was not completed.

A discharge finding may be based on one of the following:
a) no need for NF level of services and no need for specialized services, regardless of length of stay;
b) no need for NF level of services and need for specialized services, for a NF resident of less than 30-months; or
c) need for specialized services, regardless of need for NF level of services, for a NF resident of less than 30-months.

As part of its decision-making protocol, the Medicaid NF Audit Team should:
a) get a copy of the "current" Level II: Mental Health Assessment or MR/DD assessment from the NF;
b) determine whether there has been a "significant change" in the resident's mental or DD condition since the last Level II was completed; and

CHAPTER 15
PASRR AND THE MEDICAID WAIVER

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CHAPTER 15
MEDICAID WAIVERS AND PASRR

15.1 PASRR RELATIONSHIP TO MEDICAID WAIVERS

The following supplements procedures given in Chapter 7 of this Manual. Medicaid Waiver Services are those specific in-home and community-based services available for Medicaid reimbursement only under a federally approved "waiver" of certain federal regulations.

PASRR applies to:
a) Indiana's "Aged and Disabled (A&D) Waiver;"
b) Indiana's "Medically Fragile Children's (MFC) Waiver;" and
c) Indiana's "Traumatic Brain Injury (TBI) Waiver;"
two (2) of Indiana's Medicaid Waivers which provide services to aged adults and persons with disabilities who would otherwise require the level of services provided in a NF.

In addition, the ICF/MR and Autism Waivers require a complete PASRR PRIOR to NF admission and do not qualify for the "freedom of choice" provision to enter a NF.

Recipients of these Waivers must be given the "choice" between receipt of Medicaid Waiver services or admission to a NF. Therefore, he or she must meet all requirements for NF placement.

NOTE: As always, the NF must not admit any applicant without IPAS and/or PASRR approval for NF temporary or long-term admission.

15.2 GENERAL ELIGIBILITY REQUIREMENTS

For general instructions, also review Chapter 7 of this Manual. Medicaid Waiver eligibility requires that the individual must be:
a) eligible for Medicaid; and
b) at risk of institutionalization (in the absence of Medicaid Waiver services).

The criterion of "at risk of institutionalization" means that the individual must, but for utilization of the Medicaid Waiver service(s), meet all requirements for NF admission and residency. An individual who qualifies for the Medicaid Waiver must be given a choice to accept the Medicaid Waiver service(s) or be admitted to a NF.

15.3 PASRR REQUIRED

IPAS program requirements must be met when an individual applies for Medicaid Waiver services. PASRR requirements, however, do not apply until the time that the recipient chooses placement in a NF.

PASRR criteria, applied at the time that NF placement is chosen, includes:
a) the entire Level II assessment and determination, if needed, completed PRIOR to NF admission; or
b) temporary admission under PASRR Exempted Hospital Discharge, PASRR Respite or PASRR APS categorical determination, if all requirements are met.

Both the selected NF and the Waiver case manager have responsibilities for NF admission of Medicaid Waiver recipients.

15.3.1 NF Action

Often the NF will be the first entity to identify that an applicant is on a Medicaid Waiver. The NF should:

a) ask the applicant or legal representative when completing or reviewing the IPAS Application whether the applicant receives Medicaid Waiver services; and
b) review Level I and other information for need for PASRR Level II.

- When a Medicaid Waiver recipient does not need PASRR Level II, the NF:
  a) may admit the individual after receiving a copy approving NF placement on either:
     1) PAS Form 4B (Appendix P); or
     2) Medicaid Waiver form, HCBS Form 3: Statement for Freedom of Choice (Appendix S); and
  b) must notify the IPAS agency of the admission.

NOTE: When the above criteria are met, IPAS should not be completed again. The NF will seek Medicaid reimbursement following directions in Chapter 15.4.

- When a Medicaid Waiver recipient does require PASRR Level II, the NF will:
  a) not admit the individual; and
  b) obtain a determination form approving NF placement which is either:
     1) PAS Form 4B (Appendix PAS); or
     2) Medicaid Waiver Form, HCBS Form 3: Statement for Freedom of choice (Appendix S); and
  a) immediately notify the IPAS agency to trigger the PASRR Level II assessment.

NOTE: Only the IPAS agency can authorize the CMHC or D&E Team to complete a Level II for the Medicaid Waiver recipient. The Level II will be done for PAS.

15.3.2 IPAS Agency Action

The IPAS agency may find out that a Medicaid Waiver recipient is choosing NF placement from a number of sources: the case manager, the NF, the recipient.

When PASRR Level II is needed, the IPAS agency will:

a) review and certify need for Level II;
b) immediately notify the CMHC or D&E Team to complete a PAS Level II;
c) prepare a case packet containing the following documentation:
   1) Application for Long-Term Care Services;
   2) PASRR Level I;
   3) HCBS Form 3 or HCBS Form 7;
   4) PASRR Level II;
   5) additional documentation as submitted or necessary;
   6) PAS Form 4A;
c) assure notification of intent to enter a NF is given to the Medicaid Waiver case manager;
d) submit the case packet to the State PASRR Unit for review and determination; and
e) finalize the case according to IPAS and PASRR procedures.

Before submitting the case packet, the IPAS agency should make a clear, visible notation on the first page that it is a "Medicaid Waiver case."

When the NF takes a new Application for Long-Term Care Services in error, the IPAS agency will:

a) mark the Application as "Void;"
b) return it to the originating NF; and

c) assure that the NF has a copy of the HCBS form and understands the process for Medicaid Waiver.

15.3.3 Medicaid Waiver Case Manager Action

Although the NF is responsible to assure that Level II is completed within program requirements, the Medicaid Waiver case manager will need to take action to discontinue the Medicaid Waiver services.

The Waiver case manager will:

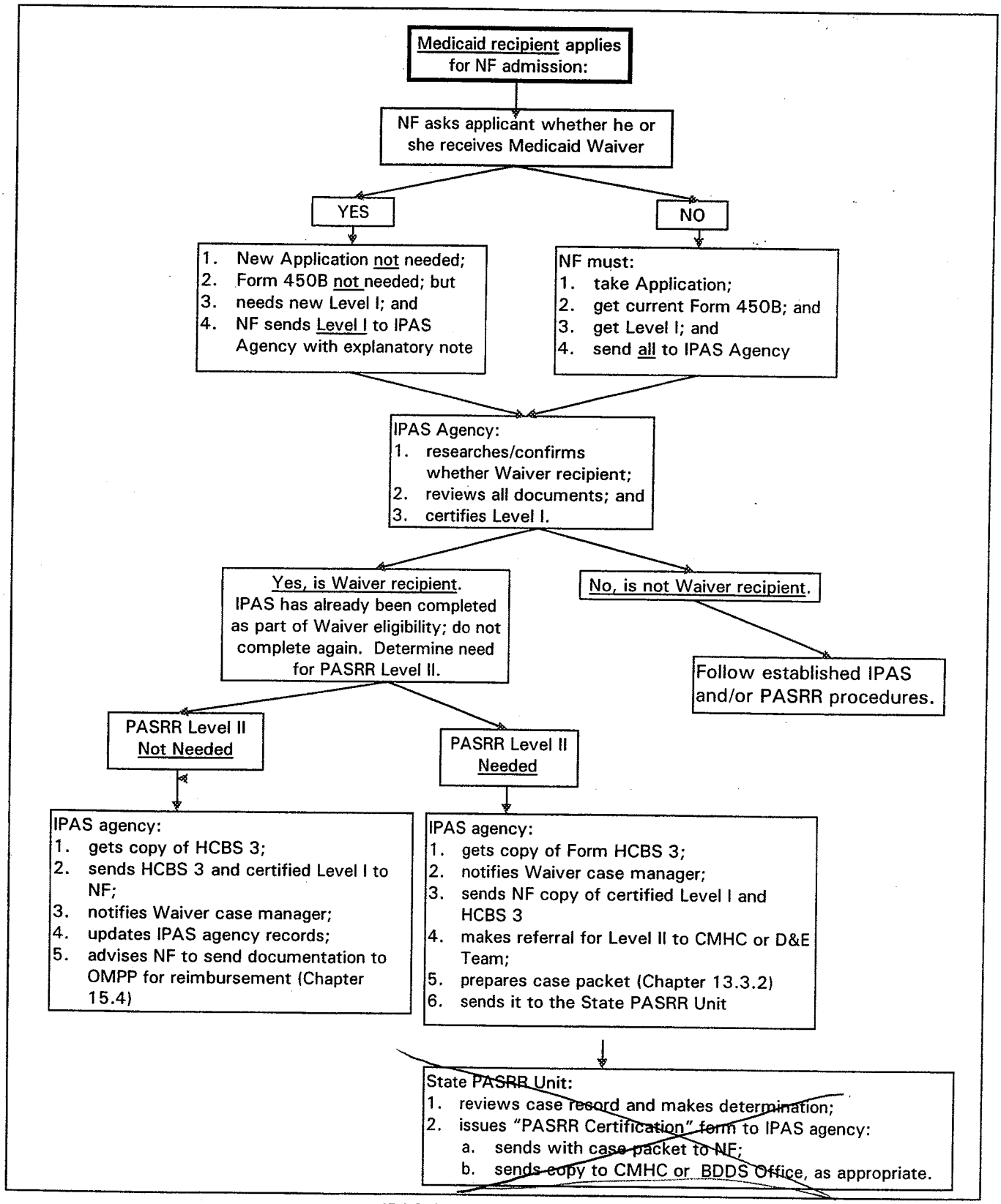
a) verify that the recipient is planning to enter the NF;
b) ascertain proposed length of stay; and
c) follow Medicaid Waiver procedures to discontinue services and do necessary follow-up.

15.4 NF REQUEST FOR MEDICAID REIMBURSEMENT

Following usual procedures, a NF can request Medicaid per diem reimbursement. When PASRR is required, the NF will receive a PASRR Certification form with the PASRR portion of the IPAS/PASRR determination. Then NF will:

a) request Medicaid reimbursement in the usual manner;
b) attach a copy of the:
   1) HCBS 3 (instead for the Form PAS 4B); and
   2) PASRR Certification form; and
c) clearly mark the submission to OMPP as, "Medicaid Waiver Services recipient transferring to the NF" or a similar notation.

NOTE: See flow chart for PASRR and Medicaid Waiver on next page.


Medicaid recipient applies for NF admission:
NF asks applicant whether he or she receives Medicaid Waiver
YES
NO
1. New Application not needed;
2. Form 450B not needed; but
3. needs new Level I; and
4. NF sends Level I to IPAS Agency with explanatory note
NF must:
1. take Application;
2. get current Form 450B; and
3. get Level I; and
4. send all to IPAS Agency
IPAS Agency:
1. researches/confirms whether Waiver recipient;
2. reviews all documents; and
3. certifies Level I.
Yes, is Waiver recipient. IPAS has already been completed as part of Waiver eligibility; do not complete again. Determine need for PASRR Level II.
No, is not Waiver recipient.
Follow established IPAS and/or PASRR procedures.
PASRR Level II Not Needed
PASRR Level II Needed
IPAS agency:
1. gets copy of HCBS 3;
2. sends HCBS 3 and certified Level I to NF;
3. notifies Waiver case manager;
4. updates IPAS agency records;
5. advises NF to send documentation to OMPP for reimbursement (Chapter 15.4)
IPAS agency:
1. gets copy of Form HCBS 3;
2. notifies Waiver case manager;
3. sends NF copy of certified Level I and HCBS 3
4. makes referral for Level II to CMHC or D&E Team;
5. prepares case packet (Chapter 13.3.2)
6. sends it to the State PASRR Unit
State PASRR Unit:
1. reviews case record and makes determination;
2. issues "PASRR Certification" form to IPAS agency:
a. sends with case packet to NF;
b. sends copy to CMHC or BDDS Office, as appropriate.

CHAPTER 16
RR/PASRR "CHOICE" FOR SPECIALIZED SERVICES

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CHAPTER 16
RR/PASRR "CHOICE" FOR SPECIALIZED SERVICES

16.1 "CHOICE" OF SPECIALIZED SERVICES' SETTING

Federal regulations provide that certain residents may, under specific circumstances, remain in a NF to receive "RR/PASRR specialized services when they would not ordinarily qualify for continued placement.

(See Chapter 13.5 for PASRR "specialized services.")

When a resident qualifies, information on the "RR/PASRR Choice" options and the treatment decision must be provided to the resident and/or his or her legal representative.

16.2 "RR/PASRR CHOICE"

For PASRR purposes, a "long-term resident" is a NF resident who has resided continuously in one or more NFs including brief hospitalization.

The "RR/PASRR Choice" refers to
a) does NOT require NF level of services;
b) does need specialized services; and
c) has continuously resided in a NF for at least 30 consecutive months before the date of the RR determination;
d) may choose to receive the specialized services:
   1) while continuing to reside in the NF; OR
   2) in an alternative appropriate institutional or noninstitutional setting.

This "30-month" qualifier:
a) only applies to the RR of PASRR; and
b) all requirements stated above must be met.

In this situation, need for RR/PASRR specialized services is the only need which qualifies the individual for continued NF placement Thus, the resident must receive the identified specialized services or he or she cannot continue to reside in a Medicaid-certified NF.

16.1.1 Qualifying Criteria

Persons eligible for the "RR/PASRR Choice" option must meet ALL of the criteria listed below.

a) NF Resident. The individual must be a current resident of a Medicaid-certified NF.
b) Does NOT Need NF Level of Services. The individual must be determined by PASRR RR NOT to need the NF level of services.
c) Not a danger to self or others. The individual's severe behavioral problems which constitute a potential danger to self or others must be controllable with the provision of specialized services.
d) Is MI and/or MR/DD. The resident's condition must meet the PASRR criteria for MI and/or MR/DD.
e) Needs specialized services. The resident's need for treatment of his or her MI and/or MR/DD condition must be of an intensity to qualify as PASRR specialized services.
f) Resident of a NF for 30-Months or More. For PASRR purposes, an individual is a long-term NF resident if he or she has resided continuously in a NF for 30-months or more, regardless of short-term care in an acute-care hospital (not a state psychiatric facility).

16.2.2 Process to "Offer the RR/PASRR Choice"

When all of the conditions listed above are met, the resident may be offered the "choice" of setting in which to receive his or her specialized services.

16.2.1 Presentation of the "RR/PASRR Choice"

For residents with MI, the local (contact the State PASRR Unit at BAIHS) will contact the resident and offer the "choice."

For residents with MR/DD, the BDDS Field Services Office will be responsible to offer the "choice."

16.2.2 Contents of Presentation.

The following information must be presented to the resident and/or his or her legal representative:

a) information on institutional and non-institutional alternatives covered under the State Plan (Medicaid) for the resident;

b) the "choice" of receiving specialized services in an alternative institutional or non-institutional setting or in the NF;

NOTE: Based on the definition of MI specialized services (services equivalent to inpatient psychiatric hospital care), it usually is not possible for a NF to establish and provide MI specialized services within the NF setting for the individual who needs them.

Due to the episodic nature of most MI, short periods of specialized services treatment may be needed rather than long-term placement. When it is anticipated that provision of specialized services will be for a brief period, and result in stabilization of the condition so that readmission to the NF is possible, the "PASRR/MI Choice" option will not be applied.

NECESSARY TREATMENT AND SERVICES SHOULD ALWAYS BE OBTAINED AS QUICKLY AS POSSIBLE AND SHOULD NOT BE DELAYED AWAITING COMPLETION OF THE PAPERWORK INVOLVED WITH THE LEVEL II PROCESS.

c) explanation that refusal to participate in specialized services will result in discharge from the NF; and

d) clarification of the effect on eligibility for services under the State Plan (Medicaid) if the person chooses to leave the NF (including its effect on readmission to the NF). If this option is chosen, the NF is responsible for doing adequate discharge planning.

16.3 General Guidelines and Procedures

Procedures may need to be adjusted to meet the needs of Individual situations. The following guidelines will assist the (contact the State PASRR Unit at BAIHS) or BDDS Field Services representative to offer the "RR/PASRR Choice."

Note: In no event will the NF or other potential service provider perform this function.

16.3.1 Procedures

a) Identification and Referral. For MI individuals, the State PASRR/MI program specialist will review the RR determinations and make a referral of those residents who qualify for this provision to the State (Contact the State PASRR Unit at BAIHS).

For MR/DD individuals, the BDDS Field Services staff will monitor RR determinations and assure that residents who qualify for this provision are appropriately referred.

b) The referral will be documented in writing in the resident's PASRR/RR case record. As much information as possible relative to the PASRR case will be provided to the identified presenter.

c) The PASRR presenter (contact the State PASRR Unit at BAIHS or BDDS representative) will contact the resident and his or her legal representative, as well as the NF, to set up a meeting. All activities are to be documented in writing in the case record. The findings with the case record will follow the determination procedures for an RR. The PASRR presenter should retain a copy of the records on file.

The purpose of the meeting is to present the PASRR/RR finding, to review all alternatives or options, to answer questions and clarify issues, and to elicit and record the resident's choice. The NF may assist with setting up the meeting, but must refrain from exerting any influence with the resident. Questions should always be referred to the PASRR presenter. In order to maintain objectivity, the NF or other potential service provider should not attend the meeting, but may provide information to the PASRR presenter.

d) The resident's choice and other pertinent information are recorded in the PASRR case record. The original case is sent to the State PASRR Unit, a copy of the decision is provided to the resident and his or her legal representative, and a copy retained by the PASRR presenter.

16.3.2 PASRR/MI Guidelines

The following procedures, initially developed to meet Indiana's Alternative Disposition Plan (ADP), will be followed to assure that specialized services are available for MI residents identified above who agree to receive them.

a) Refer the identified individual to become a client of the local CMHC, if he or she is not already being followed by a CMHC.
b) Move the individual to an inpatient psychiatric unit housed in, or under contract to, the CMHC.
c) Each individual may be provided with an average of twenty (20) days of inpatient psychiatric care.
d) Individuals whose conditions have stabilized during inpatient treatment in the CMHC may be placed in appropriate residential programs, including but not limited to: supervised group living for persons with MI; semi-independent living for persons with MI; alternative family for adults with MI; and alternative family for children with serious emotional disturbance.
e) Individuals whose conditions have not stabilized within 20 days should be referred for placement in state operated psychiatric hospitals.

NOTE: It is noted that the Division of Mental Health does not have the authority to require individuals to accept mental health services unless that person Is involuntarily committed by court action. Otherwise, the individual has the right to refuse treatment.

For the purposes of this legislation, the resident or his or her legal representative acting in his behalf will be offered alternative services. Anyone not committed to the Division of Mental health has the right under state law to refuse services.

However, a Medicaid-certified NF is prohibited from retaining any resident needing specialized services but refusing such services.

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CHAPTERS 17, 18 & 19
RESERVED FOR FUTURE USE

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APPENDICES

The list of Appendices contains both addendums and forms used in the IPAS and PASRR programs. The addendums are documents that will assist the reader in following the IPAS/PASRR Program Manual. The forms are listed by the "Program" for which they are used.

Forms are provided free of charge to entities required to participate in the IPAS and PASRR programs. Please submit your forms request on your letterhead, listing both the form number and document title, to the following address:

Department of Administration
Forms Distribution Center
6400 E. 30th Street
Indianapolis, IN 46219
Telephone: 317-591-5228

State agencies should submit requests for forms on State Form (SF) 1140, Request for Distribution of Forms and Publications.

Appendices for IPAS/PASRR Program Manual

IPAS/PASRR Program Manual (TM #3: 01/01/00)

Code	Program	Form Number	Document Title
A	IPAS/PASRR	NA	Acronyms
B	IPAS/PASRR	NA	Definitions
C	PASRR	NA	Definition of a) Mental Illness (MI); and b) Mental Retardation/ Developmental Disability (MR/DD)
D	IPAS/PASRR	NA	Hospital-Based NF-Unit Worksheet
E	IPAS	NA	a) Chart: Class A Infraction &/or IPAS Penalty b) Letter: Report of Class A Infraction (See Appendix Q)
F	IPAS/PASRR	NA	Level I: Decision-Making Protocol
G	PASRR	NA	Legal Basis for Dementia Documentation Requirement
H	PASRR	NA	a) DSM III-R: Diagnostic Criteria for Dementia, and b) Dementia Information Sheet
I	PASRR	NA	Mental Health Service Definitions for PASRR/MI Level II
J	IPAS/PASRR	NA	42 CFR 482.43: Medicare Conditions of Participation for Hospitals: Discharge Planning
K	IPAS/PASRR	SF 47178/BAIS 0025	FAX Cover Sheet
K-1	IPAS	NA	IPAS Information Sheet (Use with Application form)
L	IPAS	SF 45943/BAIS 0018	Application for Long-Term Care Services
M M-1	IPAS/PASRR	SF 38143/Form 450B I-III SF 49120/OMPP 450B SA/DE	a) Physician Certification for Long-Term Care Services b) Nursing Facility Level of Service State Authorization and Data Entry
N	IPAS	SF 45528/BAIS 0013	Eligibility Screen

O	IPAS	SF 706/PAS Form 4A	IPAS Recommendation of Screening Teams
PAS	IPAS	SF 707/Form 4B	IPAS Assessment Determination
Q	IPAS	NA	Report of Class A Infraction to County Prosecuting Attorney
R	IPAS	SF 46018/HCBS 7	Waiver Determination Form: Transmittal for Medicaid Level of Care Eligibility
S	IPAS	SF 46016/HCBS 3	Waiver Determination Form: Statement of Freedom of Choice
T	PASRR	(Open)	(Open)
U	PASRR	SF 45277/Form 450B IV-V	Level I: Identification Evaluation Criteria
V	PASRR/MI	SF 47179/BAIS 0026	Screen for Depression
W	PASRR	SF 45932/Form 450B V-B	PASRR Categorical Determination for Short-Term Nursing Facility Care: Respite Care and APS
X	PASRR	NA	Notice of Referral for Level II (Letters for MI and MR/DD)
Y	PASRR/MI	SF 47182/BAISs 0029	Dementia Assessment Checklist
Z	PASRR/MI	SF 47185/Bais 0036	PASRR/MI Level II: Mental Health Assessment
AA	PASRR/MI	SF 47183/BAIS 0030	PASRR/MI Level II Mental Health Assessment Summary of Preliminary Findings
BB	PASRR/MI	SF 47180/BAIS 0028	PASRR/MI Inappropriate Referral for Level II Assessment
CC	PASRR/MI	SF 47176/BAIS 0032 (Elect.)	PASRR/MI PAS Level II Certification
DD	PASRR/MI	(Open)	(Open)
EE	PASRR	SF 47184/BAIS 0031	PASRR/MI CMHC ARR Referral Checklist
FF	PASRR/MI	SF 47177/BAIS 0027 (Elect.)	PASRR/MI RR Problem Case Return Letter
GG	PASRR/MI	NA	PASRR/MI RR Referral Letter to ISDOH
HH	PASRR/MI	NA	PASRR/MI RR Determination Form Letters
HH-1	PASRR/MI	SF 47181/BAIS 0033	Specialized Services Alternative Documentation for Nursing Facility Residents (Offering "Choice")
II	PASRR/DD	SF 45278/Form 450B VI	PASRR/DD: Certification by Physician for Long-Term Care Services and Physical Examination for PASRR Level II
JJ	PASRR/DD	SF 46922/BAIS 0024	PASRR/DD: Pre-Admission Screening/Resident Review Certification for Nursing Facility Services
KK	PASRR/DD	SF 46921/BAISS 0023	PASRR/DD: Definition of Specialized Services for PAS/RR
LL	PASRR/DD	SF 46920/BAIS 0022	PASRR/DD: PAS/ARR Residential Alternative Documentation for Nursing Facility Residents
MM	PASRR/DD	NA	PASRR/DD: RR Determination Letter
NN	(Open)	(Open)	(Open)
OO	(Open)	(Open)	(Open)
PP	(Open)	(Open)	(Open)
QQ	(Open)	(Open)	(Open)

ACRONYMS
Commonly Used for IPAS and PASARR

(Acronyms 1/96)

AAA or COA	*Area Agency on Aging or Council On Aging*
BAIHS/BAIS	*Bureau of Aging and In-Home Services*
BDDS	*Bureau of Developmental Disabilities Services*
CFR	*Code of Federal Regulations*
CMHC	*Community Mental Health Center*
DDARS	*Division of Disability, Aging & Rehabilitative Services*
DFC	*Division of Families and Children*
DMH	*Division of Mental Health*
DSM-(#)	*Diagnostic and Statistical Manual of Mental Disorders, (#) Edition*
FSSA	*Family and Social Services Administration*
HCFA	*Health Care Financing Administration (a division of the federal Department of Health and Human Services; Chicago is the Regional Office)*
ICF/MD	*Intermediate Care Facility for Mental Diseases*
ICF/MR	*Intermediate Care Facility for the Mentally Retarded*
IMD	*Institution for Mental Diseases*
IPAS Agency	*(Local entity designated to administer IPAS program)*
IPAS	*Indiana's PreAdmission Screening*
Level I	*Screen used to identify persons who have (or are suspected of having) a condition of MI and/or MR/DD and, therefore, need to undergo further assessment*
Level II	*Assessment to establish condition and identify necessary services*
Level II Exclusion or Categorical Determination	*Conditions under which a person may be admitted to a NF without a Level II (Dementia exclusion) or prior to the final determination, including Respite Care, APS, CCRC 5-Day, or Exempted Hospital Discharge*
LP ICF/MR	*Large Private ICF/MR*
MI	*Mentally Ill*
MR/DD	*Mentally Retarded/Developmentally Disabled*
NF (or NH)	*Nursing Facility (or Nursing Home)*
NF LOS	*Nursing Facility Level of Services (formerly Level of Care)*
OBRA	*Omnibus Budget Reconciliation Act 1987 and 1990)*
OMPP	*Office of Medicaid Policy and Planning*
PAS	*PreAdmission Screening*
PASARR	*PreAdmission Screening and Annual Resident Review*
SDC	*State Developmental Center*
Specialized Services	*For PASARR purposes: MI specialized services are equivalent to the level of treatment in inpatient psychiatric care; MR/DD specialized services are equivalent to services in an ICF/MR.*
SK or IC	*Skilled nursing care or Intermediate Care*
SOF	*State Operated Facility (State Psychiatric Hospital)*
State Plan	*Agreement with HCFA for Medicaid operations*

IPAS and PASRR Definitions

The following definitions are written to specifically address terms used in Indiana's PreAdmission Screening (IPAS) and the federal PreAdmission Screening and Annual Resident Review (PASRR) programs. Each term may have other meanings and applications not covered in this document.

Admission Date: The date that an individual is physically admitted to a NF and an active record is opened for that individual.

An individual is not an endangered adult (1) solely for the reason that the individual is being provided spiritual treatment in accordance with a recognized religious method of healing instead of specified medical treatment and (2) if the individual would not be considered to be an endangered adult if the individual were receiving the medical treatment.

Applicant: The individual who makes an application or on whose behalf an application is made.

Application: The act of requesting a screening or assessment to comply with program mandates. The written or printed form on which the request is made. (Long-Term Care Services Application/IPAS Application form)

Assessment: A review of an individual's medical condition and resulting functional deficits in necessary activities of daily living, positive traits, and need for care.

Available: Readily obtainable and of sufficient scope and duration to meet the individual's identified needs; if payment is required, there must be a source of reimbursement.

BDDS Field Office: The locally-based entity which is staffed by Field Services Coordinators. There are eight (8) offices located statewide. (See Appendix BB for address and phone numbers.)

BDDS Field Services Coordinator: An individual employed by the BDDS Field Services Office who is responsible for assisting in assessing service needs for MR/DD individuals, providing case management of services, and offering the PASRR "choice".

Bureau of Aging and In/Home Services (BAIHS): A division within DDARS which administers services for the elderly and disabled pursuant to the Older Americans Act (42 USC 3001 et seq.), the Social Services Block Grant aging programs (42 USC § 1397), and Indiana Code § 12-10-10.

Bureau of Developmental Disabilities Services (BDDS): The entity within DDARS

which is responsible for the receipt and processing of applications for persons who have or are suspected of having a condition of developmental disability and administering services for individuals with developmental disabilities.

Case Determination: The final decision or finding, verbal and/or written, based on a review of submitted written documentation.

Certified Beds: A comprehensive bed which will function as a bed licensed or to be licensed under IC 16-28-1 which is certified or to be certified for participation in a state or federal reimbursement program, including programs under Title XVIII or XIX of the federal Social Security Act.

CMHC Liaison or PASRR Contact Person: The individual employed by the CMHC who is designated to interact with the IPAS and PASRR programs, to perform Level II assessments for MI persons, and to act as an intermediary within the mental health system on behalf of these programs.

Community Mental Health Center (CMHC): A locally-based service agency designated by the State mental health authority to receive moneys, provide mental health services, and act within the parameters of a CMHC defined in the federal Community Mental Health Centers Act (42 USC § 2681 et seq. and State law IC §12-7-2-38).

Community: The county in which the individual resides and significant contiguous counties that serve the individual's needs.

Comprehensive Care Facility: An institutional setting licensed under IC 16-28-2 and 410 IAC 16.2-1-8by the Department of Health, Division of Long-Term Care, that provides nursing care, room, food, laundry, administration of medications, special diets, and treatments, and that may provide rehabilitative and restorative therapies under the order of an attending physician. (Also commonly referred to as a "health facility," "nursing facility," or "nursing home.")

Comprehensive Care Beds: Beds in a licensed facility which provide room, board, laundry, administration of medications, under the supervision of an attending physician and supervisory nurse, nursing care, objective measurements of changes in a patient's condition and rehabilitation measures.

Comprehensive care facilities may be private-pay only, Medicare-certified, or Medicare/Medicaid-certified.

Continuing Care Retirement Community (CCRC): A life-care multi-level living arrangement consisting of several settings intended to meet an individual's needs at various stages of life. Usually includes individual dwellings, apartments, nursing facility, etc. Parameters of individual care are outlined and provided in a life-care contract

executed between the individual and the CCRC.

Diagnosis: The term denoting name of the disease a person has or is believed to have. The determination of the nature of a disease.

Division of Disability, Aging and Rehabilitative Services (DDARS): A division of FSSA which administers programs dealing with disability, vocational rehabilitation, aging and related areas.

Division of Mental Health (DMH): A Division of FSSA which administers mental health services.

Endangered Adult: Adult Protective Services (IC 12-10-3-2) defines "endangered adult" to mean an individual who is (1) at least eighteen (18) years of age; (2) incapable by reason of insanity, mental illness, mental retardation, senility, habitual drunkenness, excessive use of drugs, old age, infirmity, or other incapacity of wither managing the individual's property or providing self-care, or both; and (3) harmed or threatened with harm as a result of neglect, battery, or exploitation of the individual's personal services or property.

Extended Care Facility (ECF), Transitional Care Unit (TCU), Essential Care Unit (ECU), etc: Subacute care or non-acute care beds or sections physically located within the confines of an acute care hospital. These beds are usually used for such purposes as extended recuperative care for hospital inpatients, as a holding bed area for individuals awaiting transfer to a free-standing NF, or for other designated purposes specified by the hospital with the approval of the Department of Health.

Family and Social Services Administration (FSSA): The single state agency comprised of programs from the former Departments of Human Services, Public Welfare, and Mental Health.

For purposes of IPAS and PASRR, the terms nursing facility and comprehensive care facility do not include an intermediate care facility for the mentally retarded (ICF/MR), institutions for mental diseases (IMDs), or facilities licensed for residential care.

Home and Community-Based Services (HCBS): an array of services available or provided within an individual's home setting or in the community, which allows the individual to remain in the community rather than be placed in an institutional (NF or other) setting.

Hospital Discharge Planner: An employee of an acute-care hospital who is responsible for performing the necessary activities associated with evaluation of needs including appropriate post-hospital services, availability of necessary services, appropriate arrangements for services, and linkage to service providers following discharge from the

hospital.

Hospital: For purposes of PASRR, an institution providing ***acute medical and surgical treatment*** of the sick and injured licensed under IC 16-21-2 by the Department of Health, Acute Care Services Division. Per IC § 16-18-2-174 et seq., an institution, a place, a building, or an agency that holds out to the general public that it provides care, accommodations, facilities, and equipment, in connection with the services of a physician, to individuals who may need medical or surgical services.

Institution for Mental Disease (IMD): For Medicaid purposes, an IMD is defined as a hospital, NF, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Regulations also indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.

ICF/MR: (Intermediate Care Facility for the Mentally Retarded) A facility for the mentally retarded/developmentally disabled which provides active treatment for each developmentally disabled resident. In addition, the facility is only for developmentally disabled residents and the facility shall be designed to enhance the development of these individuals to maximize achievement through an interdisciplinary approach based on development principles, and to create the least restrictive environment.

IPAS (Indiana's PreAdmission Screening): The assessment process required by Indiana laws, IC 12-10-12 and 460 IAC 1-1, consisting of an application, comprehensive needs assessment, plan of care, comparison of costs in a NF versus available home and community-based services. It results in a finding or decision, ongoing or time-limited, of the appropriateness of placement in a NF.

IPAS Agency: The local entity designated by DDARS and under contract with the OMPP to administer the IPAS program and perform IPAS assessments. Currently they are synonymous with the sixteen (16) Area Agencies on Aging (AAA).

IPAS Area Manager: An individual employed by the IPAS agency who is responsible for over-all program operations. The individual must have a thorough understanding of the objectives and operation of the IPAS program and of long-term care services, and must be able to function effectively in a leadership position with the screening team. The area manager must be able to assure the accomplishment of the IPAS process by providing necessary direction and technical assistance.

IPAS Coordinator: An individual, employed by the IPAS agency, who has demonstrated competence in the activities associated with personal care assessment of functionally impaired individuals and care plan development.

IPAS Designee: An individual appointed by the IPAS agency, subject to the approval of BAIHS, who may authorize temporary admittance to a NF within the parameters of the IPAS program without the final approval required under IPAS.

Level I: Identification Evaluation Screen: A screening tool which consists of eight (8) questions designed to ascertain whether an individual has or is suspected of having a condition of mental illness (MI) and/or mental retardation/developmental disability (MR/DD).

Level II: PASRR Assessment: A multidimensional assessment designed to assess or evaluate the individual's condition to determine whether the PASRR definition of mental illness (MI) and/or mental retardation/developmental disability (MR/DD) is met, the need for NF services, specialized services, and/or services of a lesser intensity than specialized services.

Licensed Health Facility Administrator: An individual employed by a licensed comprehensive care facility/NF to manage, supervise, and have general administrative charge over its operation. The administrator may or may not have any ownership interest in the facility. His or her functions and duties may be shared with one (1) or more other individuals.

Licensure under IC 16-28-2 requires compliance with the IPAS requirements.

Medicaid Waiver Services: A specific plan, approved by HCFA, under which Medicaid reimbursement may be authorized for certain medical and non-medical services not otherwise covered by Medicaid. These additional services under the Medicaid Waiver program offer supportive services that are necessary to maintain an individual (who is at risk of institutionalization) in a community setting.

Medicaid/LTC NF Audit Team: The team responsible for conducting periodic inspections pursuant to 42 CFR 456.600 - 456.614 and 405 IAC 1-2-1.

Noncertified Beds: (NCC) A comprehensive bed which will function as a bed licensed or to be licensed under IC 16-28-1 or used as a bed licensed under IC 16-28-1 and which is not certified or proposed to be certified for participation in a state or federal reimbursement program, including programs under Title XVII or XIX of the federal Social Security Act. A noncertified bed is the same as a private pay bed.

Nursing Facility (NF)/Health Facility: For purposes of PASRR, see "Comprehensive CareFacility."

Office of Medicaid Policy and Planning (OMPP): A Division of FSSA, designated as the single State agency for administration of the Medicaid program under IC 12-15.

PASRR (PreAdmission Screening and Annual Resident Review): The assessment

process required under federal law, P.L. 100-203, OBRA '87 (42 USC § 1396r), designed to identify persons with mental illness (MI) and/or mental retardation/developmental disability (MR/DD), provide an assessment of the condition of MI and/or MR/DD, identify needed services, and determine whether NF placement or residence is appropriate.

Per diem reimbursement in an IMD is not a Medicaid covered service under Indiana's Medicaid program.

Physician: A duly licensed medical practitioner who is the applicant's medical doctor of choice, as designated by the applicant at the time of application for IPAS. The physician must know or be able to obtain knowledge of the individual's overall functioning abilities and specialized service needs.

Plan of Care/Care Plan: A comprehensive listing of an individual's functional impairments and resulting care needs, goals and objectives planned to meet or offset those needs, necessary services identified and the source of services.

Primary or Principal: The first or foremost, as a disease or symptoms to which others may be secondary or occur as complications.

Primary Physician: The physician to whom an individual or family goes initially for checkup or when ill.

Residential Beds: A bed in a care unit that provides room, food, laundry, and occasional assistance in daily living for residents who need less services than the degree of services provided by a comprehensive care facility.

Responsible Party: An individual chosen by an applicant or authorized by law (e.g., guardian, health care representative, health care power of attorney, individual authorized to make decisions under the Health Care Consent Act), or a parent if the applicant is a minor, who fills out an application for IPAS for an individual. NOTE: If there is a guardian, he or she must always sign all applicable documents.

Secondary: Next to or following; second in order.

Services: Formal or informal assistance given to meet an individual's identified needs.

State MI and/or MR/DD Authority: As used for PASRR purposes, the entity(ies) designated within the State to establish and operate the assessments and determinations required by 42 USC § 1396r for PASRR and 42 CFR § 483.100 et seq..

State Plan or Medicaid State Plan: The State Medicaid Plan for the Medicaid program (IC § 12-7-2-186).

The acute-care hospital discharge planner may be appointed by the local IPAS agency, with approval of BAIHS, to function as an IPAS program designee to authorize "direct from hospital" temporary admissions to NFs. The designated discharge planner will base such approval on the applicant's need for care as demonstrated in a review of the hospital's record ("substantially complete assessment").

The Indiana Code (IC) cite under which these beds are licensed depends primarily on who administers the unit. If the hospital retains full control and administration over the unit, it is usually licensed under IC 16-21-2. However, if the unit operates independently of the hospital administration, either under contract or subcontract to another entity or through another means, it is usually licensed under IC 16-28-2.

The individual must be physically in the NF through midnight in order for the date to be considered as an admission.

PASARR / MI SPECIALIZED SERVICES ALTERNATIVE DOCUMENTATION FOR NURSING FACILITY RESIDENTS

State Form 47181 (1-97) / BAIS 0033

HH-1

Name of resident
Name of facility
Address of facility (*number and street, city, state, ZIP code*)

I. ☐ 1. Individual qualifies for MI specialized services alternative. (*See back for definition.*)
☐ 2. Individual does not qualify for MI specialized services alternative.

ACTIVITIES	DATE(S)
II. Individual has: ☐ 3. had conversation / contact with alternatives presenter.	
☐ 4. had alternatives explained and offered.	
☐ 5. refused to participate / cooperate.	
Family, Guardian, Personal Representative has: ☐ 6. had conversation / contact with alternatives presenter.	
☐ 7. had alternatives explained and offered.	
☐ 8. refused to participate / cooperate.	

III. ☐ 9. Individual ☐ is ☐ is not his / her own guardian.

☐ 10. Individual ☐ can ☐ cannot make an informed decision.

☐ 11. Individual exercises his alternative
- ☐ a. decline MI specialized services and be discharged from the nursing facility;
- ☐ b. agree to receive MI specialized services in appropriate placement in:
  - ☐ 1. an inpatient psychiatric unit;
  - ☐ 2. a state operated psychiatric unit;
  - ☐ 3. a nursing facility (*if equivalent psychiatric care is provided*); or
  - ☐ 4. other:

IV. To be completed after the specialized services alternative is presented:

☐ I understand that after I am discharged from the nursing facility to an alternative placement, I cannot be readmitted to a Medicaid-certified nursing facility and Medicaid will not pay for services in a nursing facility unless my medical needs warrant return to the nursing facility **AND** I no longer need specialized services.

☐ Family/guardian/personal representative understands that after the individual is discharged from the nursing facility to an alternative placement, the individual cannot be readmitted to a Medicaid-certified nursing facility and Medicaid will not pay for services in a nursing facility unless the individual's medical needs warrant return to the nursing facility **AND** the individual no longer needs specialized services.

V. Signature of individual	Date (*month, day, year*)
Signature of family / guardian / personal representative (*circle one*)	Date (*month, day, year*)
Signature of alternatives presenter	Date (*month, day, year*)

Original: PASARR / MI Alternatives Presenter
Copy: Resident / Guardian / Legal Representative
Copy: PASARR / MI Program, DDARS / BAIHS, 402 W. Washington Street, Room W454, Box 7083, Indianapolis, Indiana 46207-7083

INSTRUCTIONS
INAPPROPRIATE REFERRAL FOR PASARR / MI LEVEL II

PURPOSE: This form has been designed to document the decision by the CMHC that referral for PASARR / MI Level II assessment is inappropriate at the time the referral is made. It will:

1. Document the reason for termination of the Level II referral and identify the entity / individual making the determination;
2. Provide notification of the decision to the IPAS agency (*for PAS*) and / or the State PASARR / MI Unit (*for ARR*);
3. Replace the Level II assessment for documentation purposes; and
4. Serve as documentation of CMHC action for reimbursement / audit purposes.

INSTRUCTIONS: Complete the form as follows:

Section 1: Identifying Information:

A. Enter the **full name of applicant (PAS) or resident (ARR)** in the following order: last, first, middle initial.

B. Enter the individual's **Social Security number** or, only if not available, the **date of birth**.

C. Enter the individual's **Medicaid number (RID)**, if appropriate.

D. Record the **home, hospital or NF address** which reflects the current location of the individual. Include the name of the hospital or NF, if appropriate.

Section 2: CMHC Name and Address

A. Enter the **name of the CMHC**.

B. At a minimum, record the city in which the main office of the CMHC is located.

Section 3: Purpose of Referral

A. **If PAS,** check the box labeled PAS and send the completed form to the originating / local IPAS agency.

B. **If ARR,** check the box labeled ARR. Differentiate whether the referral is a "routine" or "non-routine" ARR. Send the completed form with other documentation to the PASARR / MI program.

Section 4: Reason for Decision

A. On the first blank line, enter the **date the referral was received** by the CMHC from the IPAS agency or the NF.

B. Check the applicable box(es) which states the **reason** the referral for a Level II was inappropriate.

C. Write **additional information**, if applicable, in the spaces provided.

Section 5: CMHC Certification

The CMHC PASARR reviewer (*a qualified mental health professional*) must **sign** and **date** the form, with a **telephone number** and specifying his / her **title / credentials**.

INDIANA PASARR / MI PROGRAM
CMHC ARR REFERRAL CHECKLIST

State Form 47184 (9-95) / BAIS 0031

When completed, mail to: PASARR / MI Program
DDARS-BAIS
402 West Washington Street, Room W454
P.O. Box 7083
Indianapolis, Indiana 46207-7083

EE

READ THE INSTRUCTIONS ON THE REVERSE SIDE.

Page _____ of _____.

1. Name of the Community Mental Health Center	City
2. NF name	
3. NF address (*number and street, city, state, ZIP code*)	
4. Date: ☐ Routine: LTC Review Team NF Visit _____ / _____ / _____ / (*Lower right-hand corner of worksheet*) ☐ Non-Routine: NF Referral Letter / Other _____ / _____ / _____ / (*Date on NF letter*) ☐ In hospital bed ☐ In NF	
If "Other", please explain: Referral Letter Received from NF _____ / _____ / _____ (*"Date-Received" stamped on NF referral letter by CMHC*)	
5. Date:	

6. Prepared by: (*name*)	Title	Date (*month, day, year*)

7. REFERRAL LIST: (*Use name(s) or list supplied by NF.*) Name: Last First M.I.	8. Check one		9.	10. Check one		11.	12.
	Medi-caid	Priv-Pay	Date Last L-II Assmt	Purpose ARR	Purpose PAS	Date L-II Scheduled	Date L-II Completed
1.							(PSYCHIATRIST'S SIGNATURE)
2.							
3.							
4.							
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11.							
12.							
13.							
14.							
15.							

☐ ROUTINE: Attach Level II and LTC Review Team's Audit Worksheet
☐ NON-ROUTINE: Attach NF Referral Letter, Level I, Form 450B, Level II (*and, if readmitted from hospital, Letter of Assurance*)

NOTE: Case records will be sent to NF with determination letter. CMHC will be sent a copy of each deterimination letter only for the CMHC files. CMHC should keep a clear copy of all documents submitted to the State PASARR / MI Unit on file at the CMHC.

Name of applicant	Social Security number	Date of birth

IV. SUMMARY OF ASSESSMENT FINDINGS

The Level II assessment must result in independent diagnosis(es) by the evaluator, supported by the data entered in the Level II document. When more than one (1) diagnosis is listed, list them by level of intensity with the **principal / primary** diagnosis first, etc. **ENTER CURRENT DSM CODE + DIAGNOSIS FOR EACH IDENTIFIED MI CONDITION.**

I: AXIS II: AXIS III: (*From medical records / NF chart*)

AXIS I from chart (optional):

DEFINITION OF "MENTAL ILLNESS": An individual is considered to have mental illness if he / she has a current primary or secondary diagnosis of a major mental disorder (*as defined in the current Diagnostic and Statistical Manual of Mental Disorders*) limited to schizophrenic, schizoaffective, mood (*bipolar and major depressive type*), paranoid or delusional, panic or other severe anxiety disorder; somatoform or paranoid disorder; personality disorder; atypical psychosis or other psychotic disorder (*not otherwise specified*); or another mental disorder that may lead to a chronic disability; and he / she does not have a concurrent predominant (*primary or principal*) diagnosis of senile or presenile dementia (*including Alzheimer's Disease or related disorder*) or any condition determined to be mental retardation / developmental disability (MR / DD). (*See Appendix C of the IPAS / PASARR program manual.*)

A. This individual ☐ **is** ☐ **is not mentally ill as defined above.**

DEFINITION OF "MI SPECIALIZED SERVICES": Specialized Services are defined as the implementation of an individualized plan of care developed under and supervised by a physician, provided by a physician and other qualified mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an **acute episode** of severe mental illness, which necessitates supervision by trained MH personnel. A nursing facility resident with mental illness who requires specialized services shall be considered to be eligible for the level of services provided in an institution for mental diseases (IMD) or an inpatient psychiatric hospital (*subject to Medicaid reimbursement requirements*).

B. This individual ☐ **is** ☐ **is not in need of mental health specialized services / inpatient psychiatric care (as defined above).**

C. SERVICES OF LESS INTENSITY THAN SPECIALIZED SERVICES: This individual needs the following mental health services, regardless of placement. (42 CFR 483.128) **CHECK ALL THAT APPLY.**

☐ Diagnosis Review / Update by NF / Hospital
☐ Dementia Work-Up
☐ MH Case Management Services
☐ Continue Current MH Services
☐ Yearly RR Required
☐ Psychiatric Evaluation
☐ Outpatient MH Services
☐ Individual / Group Therapy
☐ Partial Hospitalization / Day Treatment
☐ Further Evaluation of Medication Side Effects
☐ Medication Review
☐ Medication Adjustment
☐ Medication Monitoring
☐ Medication Administration
☐ Needs Further Review - Specify: _____
☐ Other - Specify: _____
☐ None of the above-listed services required at this time

Identify placement options which would meet the individual's needs. Check all viable options, regardless of current availability. NOTE: Recommendations do not constitute approval for such placement.
In my opinion, if nursing facility placement is not appropriate, the following option(s) may apply.

☐ State Hospital ☐ Other Residential - Specify: _____
CMHC Residential Program: ☐ Semi-Independent Living ☐ Supervised Group Living ☐ Alternative Family Living Program
☐ Other - Specify: _____

NOTE: The results of this assessment do not determine need for NF level of services.

IF INDIVIDUAL IS IN NF, AVAILABLE RESIDENT ASSESSMENT / MDS WAS REVIEWED: ☐ Yes ☐ No Comments: _____

Assessments are required under the minimum federal criteria for states to use in making preadmission screening and annual resident review determinations about admission to or continued residence in nursing facilities for individuals who have mental illness or mental retardation. (42 CFR 483.100-138)

Signature of Evaluator	Credentials	Date	Telephone number

☐ I certify that I have reviewed the above report and concur with the findings. [42 CFR 483.134 (d)]

Signature of Psychiatrist		Date	Telephone number
	☐ Board certified ☐ Board eligible		

INDIANA PASRR PROGRAM
SUMMARY OF PRELIMINARY FINDINGS AND RECOMMENDATIONS OF PASRR / MI LEVEL II MENTAL HEALTH ASSESSMENT

AA

State Form 47183 (R3/12-99) / BAIS 0030

This form shall become a **CONFIDENTIAL RECORD** upon completion in accordance with 42 CFR 483.100 et. al.

* This State agency is requiring disclosure of your Social Security Number per IC 4-1-8-1. The information obtained on this form is confidential under state and federal regulations. This information will not be released except as permitted required by law or with the consent of the applicant.

Name of applicant / resident:	Date (*month, day, year*):	
Social Security number: *	Date of birth:	Age:
Name of NF:		
Address (*number and street, city, state, ZIP code*):		

Reason for Level II: (check one only)
A. ☐ IPAS B. ☐ YEARLY RR C. ☐ SIGNIFICANT CHANGE RR

D. ☐ MISSED LEVEL II FOR: (check one only)
☐ PAS ☐ YRR ☐ SIGNIFICANT CHANGE RR

I. Current Psychotropic Medication(s):

II. Psychiatric Diagnosis(es): (*Use current DSM code.*)

III. Based on PASRR / MI guidelines, the Level II assessment preliminarily determines that:

The individual ☐ is ☐ is not mentally ill.

The individual ☐ is ☐ is not in need of MI specialized services (*inpatient psychiatric care*).

(*See back of this form for PASRR definitions of mental illness and MI specialized services*)

IV. The individual needs the following mental health (MH) service(s) pending final determination:

☐ Diagnosis Review and / or Update by NF / Hospital
☐ Dementia Work-Up
☐ MH Case Management Services
☐ Continue Current MH Services
☐ Yearly RR Required
☐ Psychiatric Evaluation
☐ Individual / Group Therapy
☐ Partial Hospitalization / Day Treatment
☐ Further Evaluation of Medication Side Effects
☐ Medication Review
☐ Medication Adjustment
☐ Medication Monitoring
☐ Medication Administration

☐ Needs Further Review (*Specify*): _____

☐ Other (*Specify*): _____

☐ None of the above listed services required at this time ☐ MDS reviewed, if one was completed. (*May note comments below.*)

(*See IPAS / PASRR Manual, Appendices Section, for Definitions / Descriptions of MH Services.*)

V. COMMENTS: (*Include all recommendations, psychiatric and non-psychiatric, which have resulted from this assessment. Use this space to record areas or strategies for care that the NF should follow.*)

NOTE: The results of this assessment do not determine need for NF level of services.

NOTE: The CMHC assessor will complete this preliminary summary following the Level II assessment and prior to the psychiatrist's signature for all Level II assessments. It will be given to the individual, the legal representative, and the NF, as appropriate. Keep this summary on the NF's chart. Replace with the final determination packet when it is received. The NF must make these findings part of the resident's NF Resident Assessment (RA / MDS) and Plan of C

Exit conference held with: ☐ NF Director of Nurses ☐ NF Social Worker ☐ Other _____ Name:			Date of conference (*month, day, year*):
CMHC Assessor:	Credentials	Telephone number:	Date completed:
Name of CMHC:	City and state:		

PASRR/MI PROGRAM:
DEFINITIONS OF MENTAL ILLNESS AND SPECIALIZED SERVICES

C

PASRR FEDERAL RULES AND REGULATIONS (November 30, 1992): Effective January 29, 1993
Section 483.102(b) Definition of PASRR/MI Mental Illness (MI)

An individual is considered to have a serious mental illness (MI) if the individual meets the following requirements:

A. **DIAGNOSIS:**
   1. Has a diagnosis of schizophrenic, mood paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability;
   2. Does not have a primary diagnosis of dementia, including Alzheimer's disease or a related disorder;
   3. Does not have a non-primary diagnosis of dementia unless the primary diagnosis is a major mental illness as defined in number I, above.

AND

B. **LEVEL OF IMPAIRMENT:** Within the past 3 to 6 months, the disorder results in functional limitations in major life activities that would be appropriate for the individual's developmental stage.

   At least one of the following characteristics is present on a continuing or intermittent basis:
   1. **Interpersonal functioning:** serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation; **OR**
   2. **Concentration, persistence, and pace:** Serious difficulty in sustaining focussed attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks; **OR**
   3. **Adaptation to change:** serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.

AND

C. **RECENT TREATMENT:** treatment history indicates at least one of the following:
   1. **Psychiatric treatment** more intensive than outpatient care more than once in the past 2 years (e.g., partial hospitalization or inpatient hospitalization);
      OR
   2. Within the last 2 years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

Section 42 CFR 483.120(a) Definition of PASRR/MI SPECIALIZED SERVICES (SS)

I. **DEFINITION OF MI SPECIALIZED SERVICES** (Indiana Medicaid State Plan)
For PASRR/MI purposes, Specialized Services are defined as the implementation of an individualized plan of care developed under and supervised by a physician, provided by a physician and other mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of severe mental illness, which necessitates supervision by trained mental health personnel. A nursing facility resident with mental illness who requires specialized services shall be considered to be eligible for the level of services provided in an institution for mental diseases (IMD) or an inpatient psychiatric hospital (subject to Medicaid reimbursement requirements).

II. **DEFINITION OF SPECIALIZED SERVICES** [42 CFR 483.120(a)]
   (I) For mental illness, specialized services means the services specified by the State which, combined with services provided by the NF, results in the continuous and aggressive implementation of an individualized plan of care that-
      (i) Is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professionals and, as appropriate, other professionals;
      (ii) Prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness, which necessitates supervision by trained mental health personnel; and
      (iii) Is directed toward diagnosing and reducing the resident's behavioral symptoms that necessitated institutionalization, improving his or her level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

for nursing facility residents as a Level II recommendation.

When this service recommendation is made for non-nursing facility residents, a case management follow up probably better describes the recommended service and will be so stated in future detereminations.

Medications Administered: For persons not expected to be placed in a nursing facility, there is an awareness that assistance is needed for administration of medications, either due to physical limitations or a history of non-compliance.

Individual/Group Counseling: A general or specific form of counselling may be recommended. It may be performed by qualified nursing facility staff or may be referred to a mental health provider. If there is a question as to what type of counselling is recommended when it is not specified, inquiry may be made to the assessor listed on page 1 of the Level II evaluation form.

Partial/Day Treatment: This is a service provided by each Community Mental Health Center that is intended to avoid the need for in-patient psychiatric treatment. Factors such as distance, finanacial arrangements, and compliance may need to be considered to make this therapy feasible. If not feasible, an alternative therapy may be proposed. It is recommended that inquiry with the CMHC servicing the area of the facility be made.

Case Management Follow-along: Under this service, referral to a mental health provider is indicated for one or more services for continuous monitoring of a condition. The provider may consider, for example, the need for medication review and monitoring, counselling visits and a therapy program involving significant others. The provider would manage a person's mental health needs on a time table or as need arises. Inquiry should be made with the assessor listed on page 1 of the Level II evaluation form for more detail when this is a recommendation.

Diagnosis Review/Update: A review of diagnosis may be indicated for either of two reasons: 1) a discrepancy may exist between the diagnosis on record and a condition that is currently being found; or 2) the current diagnosis is expected to improve, in which case another diagnosis or no diagnosis could be the finding at a later date. The person's physician may choose to perform a review/update or make referral to a psychiatrist. A psychiatric diagnosis which no longer exists should be removed from the list of current diagnoses on record.

Needs Further Review: A psychaitric condition may be suspected, but can not be diagnosed by the time the Level II assessment must be submitted. The nursing facility or the individual's physician should arrange to have a psychiatric consultation to complete the diagnostic process and prescribe appropriate treatment.

It is expected that all recommendations resulting from the PASARR/MI Level II assesment process will be provided to the person's primary care physician and, when the person is also followed by a psychiatrist, the specific psychiatrist. All action on these recommendations should be documented in the nursing facility record, whether

the services are obtained or not. If services are not obtained, document the reason why these were not followed through or obtainable.

For questions regarding the specificity of a recommendation to a particular person, please contact the Level Ii assessor who performed the assessment, listed near the top of page 1 of the Level II form. Contact the same person if information is needed on how to obtain services.

DRAFT: (To Be Placed On IPAS Agency Letterhead)

RE:

Dear

(Form-Ref.Ltr 1/95 csw)

Individuals seeking nursing facility placement are required to participate in an assessment to determine specific service needs. Indiana's PreAdmission Screening (IPAS) program, with the needs assessment requirements of the federal PreAdmission Screening and Annual Resident Review (PASARR) program, are designed to evaluate the individual's needs and identify services to meet those needs. It will also find whether those services are more appropriately provided by some type of home-based or community service or in a nursing facility.

Under PASARR, individuals who have or may have a condition of mental illness must be referred to the local community mental health center (CMHC) for screening and an assessment of mental health service needs. The nursing facility which admits the individual must assure that appropriate services are provided to meet identified needs.

Your request for placement into a nursing facility is being processed by our IPAS program. As part of your needs assessment, a referral has been made to the community mental health center (CMHC) listed at the bottom of this letter.

An assessor from the community mental health center (CMHC) will contact you in the next few days. It is important that your assessment be completed as soon as possible to process your request for approval of nursing facility placement.

If you have any questions or would like additional information, please feel free to call me at the phone number listed below.

Sincerely,

IPAS/PASARR Program Coordinator
Phone

cc: CMHC Name/Assessor Name:
CMHC Address and Phone:

INDIANA PASARR PROGRAM
DEMENTIA ASSESSMENT CHECKLIST

State Form 47182 (9-95) / BAIS 0029

This form shall become a **CONFIDENTIAL RECORD** upon completion in accordance with 42 CFR 483.100 et. al.

* This State agency is requesting disclosure of your Social Security number, under 42 CFR 483.100 et. al. Disclosure is voluntary, and you will not be penalized for refusal.

Name of applicant / resident	Social Security number *	Date of birth

Name of nursing facility	Telephone number

Address (*number and street, city, state, ZIP code*)

DEMENTIA ASSESSMENT CHECKLIST

Federal PASARR regulations require documentation of a diagnosis of dementia (*including Alzheimers Disease and related disorders*) if an individual is excluded from PASARR / MI Level II assessment based on the dementia exclusion. An individual with a primary / principal diagnosis of a major mental illness (MI) or who is developmentally disabled (MR/DD) may not be excluded. To document the dementia diagnosis, the sections of this form may be completed or other documents which address the criteria in Sections 1-5 may be obtained. This documentation must be retained on the individual's active record in the NF. The purpose is to minimize the risk of overlooking potentially reversible conditions that may be causing or mimicking dementia.

If this form is used, ALL sections must be completed. At a minimum, the physician must sign and date the form. If sections are completed by different persons, the person completing it must also sign and date that part. Information must be current in that the patient's condition has not changed since testing results were obtained. Information may be obtained from the phyisican's current records, hospital summaries, etc.

NOTE: The nursing facility is responsible to maintain on file acceptable documentation of dementia for any person for whom the exclusion is claimed.

1. **DSM-IV Criteria:** For dementia, all areas must be checked "Yes".

☐ Yes ☐ No A. Evidence of short-term and long-term memory loss.

B. One or more of the following:

☐ Yes ☐ No 1. Impaired abstract thinking;

☐ Yes ☐ No 2. Impaired judgement;

☐ Yes ☐ No 3. Other higher cortical dysfunction (*e.g. aphasia, apraxia, agnosia, constructional dyspraxia*).

☐ Yes ☐ No C. A & B significantly interferes with work or usual activity.

☐ Yes ☐ No D. Not occurring exclusively during the course of delirium.

☐ Yes ☐ No E. Insidious onset with generally progressive deterioriating course.

☐ Yes ☐ No F. Exclusion of other specific causes of dementia by histo physical and laboratory tests. (*See sections 2-4 below*)

2. **Mental Status Examination:** At least one must be checked. Enter results and interpretation. Attach an additional page if needed.

☐ Short Portable Mental Status Questionnaire (SPMSQ) Score: _____/_____ errors

☐ Folstein Mini Mental Status Exam Score: _____/_____ errors

☐ Halstead-Reitan, Luria Nebraska or other neuropsychological assessment battery _____

☐ CAMCOG-Cambridge Cognitive Examination portion of CAMDEX Score: _____ errors

☐ Kahn-Goldfarb MSQ; Face-Hand Test Score: MSQ _____ errors

FHT _____ errors

☐ CBRS-Cognitive Behavior Rating Scale Score: _____

☐ Mattis Dementia Rating Scale Score: _____

☐ Blessed Dementia Scale Score: _____

☐ Wechsler Tests (WAIS-R or WMS-R) Scores: _____

_____ _____

☐ Other: _____ Score: _____

Interpretation(s):

Testing by: (*If Mental Status Exam done by someone other than the physician*)	Date (*month, day, year*)

Affiliation:	Credentials

(Continued on the reverse side)

DEMENTIA ASSESSMENT CHECKLIST (*Continued*)

3. MEDICAL PROCEDURES: Screening and laboratory procedures performed to either substantiate dementia or to rule out other possible causes of dementia. (*Check all that have been completed and reviewed.*)

- ☐ Medication Review to rule out medication effects
- ☐ Vision / hearing problems
- Environmental change
- ☐ Assessment for depression and other psychiatric disorders
- ☐ Brain trauma / concussion
- ☐ ASHD / CHF / Alcoholism / Anemia / etc.
- ☐ Thyroid Function
- ☐ Urinalysis
- ☐ Electrolyte Panel
- ☐ Screening Metabolic Panel
- ☐ B12 and Folate Levels
- ☐ Chest Xray
- ☐ Electrocardiogram
- ☐ Other: _____
- ☐ CBC
- ☐ CT Scan *
- ☐ MRI *
- ☐ EEG *
- ☐ PET *
- ☐ Biopsy *

Results / interpretation:

* Not required. Record results if completed for purposes other than completion of this form.

4. PATIENT / FAMILY HISTORY: As complete a history as possible should be obtained to supplement the detection of occult medical illness in number 3 above: (*NOTE: May be provided by family or other responsible party.*)

5. **ER PROCEDURES** used to substantiate diagnosis or to rule out possible causes of dementia: (*Indicate "None" if applicable.*)
Procedure(s):

Interpretation:

6. In your best judgment, is the dementia condition expected to be reversible, e.g., dementia following surgery, due to hypothyroidism, etc.? Or is it irreversible and anticipated to worsen?

☐ REVERSIBLE ☐ IRREVERSIBLE Comments: _____

If reversible, the NF should monitor and assure necessary services are provided for the individual's recovery.

7. Does the person have behavior problems?	Is the person a danger to self or others?
☐ Yes ☐ No	☐ Yes ☐ No

If Yes to number 7: Explain, including recommended strategies to deal with problems.

Information completed by (*If other than the physician*):

Name	Date (*month, day, year*)
Affiliation	Credentials

This documentation must be certified by the physician:

Signature of physician	Printed name of physician	Date (*month, day, year*)

LEVEL II: PASRR / MI MENTAL HEALTH ASSESSMENT

State Form 47185 (R5 / 4-99) / BAIS 0036

Information contained herein is **CONFIDENTIAL** according to IC 16-14-1.6-8.

Z

☐ PAS (PreAdmission Screening) ☐ New Mental Health Assessment ☐ Updated PAS	Give date of IPAS agency initial referral:	Give date returned to IPAS agency:	Send completed forms to: "LOCAL IPAS AGENCY"
☐ RR (Resident Review): ☐ Yearly RR ☐ Significant - Change RR ☐ "Missed" RR	Prior Level II done: ☐ Yes ☐ No ☐ Unknown If "Yes" complete for most-recent: (1) Check: ☐ PAS ☐ PAS Update ☐ Yearly RR ☐ Significant-Change RR (2) Give date of psychiatrist signature: _____ ☐ "Missed" RR		Send completed RR Check-list with RR Case(s) to: MS21 PASRR / MI Program, Room W454, P.O. Box 7083 Indianapolis, IN 46207-7083

Name of ☐ PAS applicant or ☐ NF resident:	Birthdate (*month, day, year*):	Age:	Sex: ☐ Male ☐ Female
Location where Level II completed (*name, address, city, state, ZIP code*) (*home or include name of facility or hospital*):		If in NF, date of initial admission:	
Name and address of CMHC or hospital completing Level II: *		Date of evaluation (*mo., day, yr.*):	

* This Level II assessment was completed by an entity which is not a nursing facility and has no direct or indirect affiliation with such facility. [P.L. 101-508, Sec. 408 (b)(1-8) and 42 CFR 483.106 (e)(3)]

I. PAS location of applicant (*check all that apply*):

- ☐ At own home / residence
- ☐ In hospital: ☐ Acute Care ☐ Non-Acute Care ☐ Psychiatric ☐ Non-Psychiatric
- ☐ In NF from home: ☐ APS ☐ Respite Stay
- ☐ Continued stay in NF beyond exempted hospital discharge
- ☐ Other: _____

II. Significant - Change RR purpose (*check all that apply*):

- ☐ Change in mental status WITHOUT hospitalization
- ☐ Change in mental status WITH hospitalization
  - ☐ In hospital (*No prior Level II*)
  - ☐ In NF (*Readmitted on basis of current Level II*)
- ☐ Other: _____

III. "Missed Level II": (*check one*)

☐ PAS ☐ Yearly RR ☐ Significant-Change RR

Private - pay: ☐ Yes ☐ No

Social Security number	Medicare number	Medicaid number

I. DRUG HISTORY

The PASRR / MI assessment process must provide a comprehensive drug history, including current and immediate past use of medications with particular attention to use of medications that could mask symptoms or mimic mental illness. [42 CFR 483.134 b(2)] The psychiatrist should review the medications for appropriateness and medication interaction.

LIST ALL CURRENT MEDICATIONS	DOSAGE / FREQUENCY	START DATE	REASON FOR PSYCHOTROPIC MEDICATIONS (*If Unknown, Explain*)

OPTION: Please see attached medication sheet. ☐ Yes ☐ No

SIGNIFICANT - CHANGE RR AND UPDATES ONLY: Reviewed current Level II: ☐ Yes ☐ No Significant changes: ☐ Yes ☐ No

INAPPROPRIATE REFERRAL (*Identified after assessment begun: Stop and complete Inappropriate Referral form.*)

PAST TWELVE MONTHS (*Major Psychotropic Drugs*)	DOSAGE / FREQUENCY	START / STOP DATES	REASON / PURPOSE FOR PSYCHOTROPIC MEDICATIONS

RR AND UPDATES ONLY: Medications reviewed: ☐ Yes ☐ No Any changes since last Level II: ☐ Yes ☐ No

Name of applicant	Social Security number	Date of birth

II. PSYCHOSOCIAL REPORT

The PASARR / MI process must include a psychosocial evaluation of the person, including current living arrangements and medical and support systems. [42 CFR 483.134 (b) (3)]

RRENT LIVING ARRANGEMENT (*Brief description*) What has been this person's residence for the last several years? How long has this person lived ne nursing facility? What is this person's stated preference of living arrangement? Is it feasible? Explain. Add any other pertinent details deemed appropriate.

SUPPORT SYSTEMS (*Family, friendships, church, associations, etc.*) What emotional support does this person have? How extensive is the support system outside the NF? Where do they live? Who actively supports the person? Explain. For PAS cases, have you contacted the persons listed? Is there a legal guardian? Is the guardianship full or limited? Include names and addresses, if available.

CAL SYSTEMS Identify this person's attending physician. (*Other pertinent medical professionals may be entered, as deemed necessary.*)

If the psychological evaluation is not conducted by a social worker, than a social worker's review and concurrence with pages 1 and 2 above is required and must be documented by a co-signature below. [42CFR 483.134 (c)] Specify social worker's credentials: LSW, LCSW, BSW, and / or MSW.

Signature of evaluator	Professional credentials	Date (*month, day, year*)	Telephone number
Co-signature (*if needed*)	Professional credentials	Date (*month, day, year*)	Telephone number

III. PSYCHIATRIC HISTORY AND EVALUATION

The PASARR / MI process must be a comprehensive assessment. At a minimum, this assessment must address the following areas: complete psychiatric history for the past 24 months, including all hospitalizations and / or out-patient episodes; evaluation of intellectual functioning, memory functioning, and orientation; description of current attitudes and overt behavior; affect; suicidal or homicidal ideation; paranoia; and degree of reality testing (*presence and content of delusions*) and hallucinations. (42 CFR 483.134) Attach copies of all available discharge summaries dated within the past 24 months. You may summarize information from records. If unavailable, note and explain.

A. NAME OF TREATMENT LOCATION	DATE OF ADMISSION	DATE OF DISCHARGE	DIAGNOSIS (*Include current DSM code whenever possible*)	DISCHARGE SUMMARY

Is this individual currently receiving mental health services? ☐ Yes ☐ No

If "Yes", specify:

Name of applicant	Social Security number	Date of birth

B. MENTAL STATUS EVALUATION *("WNL" means within normal limits. Check all box(es) that apply.)*

	WNL	VARIATIONS								
Appearance	☐	☐ Poor Hygiene	☐ Disheveled	☐ Inappropriate	☐ Bizarre	☐ Obese	☐ Thin/Emaciated	☐ Other *(Clarify below)*		
Attitude	☐	☐ Guarded	☐ Suspicious	☐ Uncooperative	☐ Belligerent	☐ Indifferent	☐ Manipulative	☐ Other *(Clarify below)*		
Motor Activity	☐	☐ Restless / Agitated	☐ Tremors / Tics	☐ Retarded				☐ Other *(Clarify below)*		
Affect	☐	☐ Constricted	☐ Stunted	☐ Flat	☐ Agitated	☐ Excited		☐ Other *(Clarify below)*		
Mood	☐	☐ Depressed / Sad	☐ Anxious	☐ Elated	☐ Hostile / Angry	☐ Euphoric	☐ Labile	☐ Other *(Clarify below)*		
Speech	☐	☐ Soft ☐ Loud	☐ Rapid ☐ Aphasic	☐ Slowed	☐ Delayed Responses	☐ Slurred	☐ Pressured	☐ Other *(Clarify below)*		
Thought Process	☐	☐ Circumstantial	☐ Tangential	☐ Loose	☐ Flight of Ideas	☐ Delusional	☐ Concrete	☐ Other *(Clarify below)*		
Thought Content	☐	☐ Paranoid	☐ Obsessional	☐ Poverty of Content		☐ Preoccupied with _____				
		☐ Hallucinations:	☐ Auditory	☐ Visual	☐ Other _____					
		☐ Suicidal:	☐ Ideations	☐ Intent	☐ Plans: Comments: _____					
		☐ Homicidal:	☐ Ideations	☐ Intent	☐ Plans: Comments: _____					
Orientation	☐	☐ Place	☐ Person	☐ Time	☐ Passage of Time			☐ Other *(Clarify below)*		
Memory	☐	☐ Recent	☐ Remote	☐ Selective	☐ Immediate			☐ Other *(Clarify below)*		
Judgment	☐	☐ Poor Impulse Control	☐ Questionable	☐ Maladaptive	☐ Co-Dependent	☐ Self-Destructive	☐ Other *(Clarify)*			
Insight	☐	☐ Has some insight	☐ Has very little insight		☐ Insight lacking	☐ Other *(Clarify below)*				
Intellect	☐	☐ Above Average	☐ Below Average		☐ Retarded	☐ Other *(Clarify below)*				
Cognition	☐	☐ Level of Consciousness	☐ Attention Span		☐ Abstract Thinking	☐ Calculation Ability	☐ Other *(Clarify)*			

C. NARRATIVE DESCRIPTION Give a narrative description of this person. Include any pertinent explanations of the MS evaluation checklist, above, or other behavioral problems identified. Additional pages / reports may be attached as needed. Address positive traits, strengths and weaknesses, and emotional needs. [42 CFR 483.128 (i)] **NOTE: This mental status description does not determine need for NF level of services.**

This person's current or past behavior presents a danger to self or others? ☐ Yes ☐ No *(If "Yes", explain.)*

H

From "DSM-III-R". Am. Psychiatric Assn.

Diagnostic criteria for Dementia

A. Demonstrable evidence of impairment in short- and long-term memory. Impairment in short-term memory (inability to learn new information) may be indicated by inability to remember three objects after five minutes. Long-term memory impairment (inability to remember information that was known in the past) may be indicated by inability to remember past personal information (e.g., what happened yesterday, birthplace, occupation) or facts of common knowledge (e.g., past Presidents, well-known dates).

B. At least one of the following:

(1) impairment in abstract thinking, as indicated by inability to find similarities and differences between related words, difficulty in defining words and concepts, and other similar tasks
(2) impaired judgment, as indicated by inability to make reasonable plans to deal with interpersonal, family, and job-related problems and issues
(3) other disturbances of higher cortical function, such as aphasia (disorder of language), apraxia (inability to carry out motor activities despite intact comprehension and motor function), agnosia (failure to recognize or identify objects despite intact sensory function), and "constructional difficulty" (e.g., inability to copy three-dimensional figures, assemble blocks, or arrange sticks in specific designs)
(4) personality change, i.e., alteration or accentuation of premorbid traits

C. The disturbance in A and B significantly interferes with work or usual social activities or relationships with others.

D. Not occurring exclusively during the course of Delirium.

E. Either (1) or (2):

(1) there is evidence from the history, physical examination, or laboratory tests of a specific organic factor (or factors) judged to be etiologically related to the disturbance
(2) in the absence of such evidence, an etiologic organic factor can be presumed if the disturbance cannot be accounted for by any nonorganic mental disorder, e.g., Major Depression accounting for cognitive impairment

Criteria for severity of Dementia:

Mild: Although work or social activities are significantly impaired, the capacity for independent living remains, with adequate personal hygiene and relatively intact judgment.

Moderate: Independent living is hazardous, and some degree of supervision is necessary.

Severe: Activities of daily living are so impaired that continual supervision is required, e.g., unable to maintain minimal personal hygiene; largely incoherent or mute.

PASARR Level I

DECISION-MAKING PROTOCOL

I. PURPOSE: This protocol will guide IPAS agencies, NFs, hospitals, CMHCs, BDDS Offices, and other entities in the completion of the PASARR *Level I: Identification Screen*. It will also provide a basis for judging and certifying the need for *Level II* referral.

The PASARR *Level I: Identification Screen* is a multi-function form designed to document several requirements on a single sheet of paper.

A. The top portion records pertinent demographic and case information to establish the nature of the PASARR case.
B. **"SECTION IV"** contains eight (8) questions to determine whether an individual needs to be referred for a PASARR *Level II* assessment due to a condition of mental illness (MI) and/or mental retardation/developmental disability (MR/DD).
C. The middle section titled, **"FOR ANNUAL RESIDENT REVIEW,"** is only completed when a co-signature is required for the ARR process.
D. **"SECTION V-PART A"** explains and documents the "Exempted Hospital Discharge" exclusion.
E. The last section titled, **"CERTIFICATION OF LEVEL II REFERRAL,"** must always be completed by the IPAS agency for PAS cases and by the NF for ARR situations. The *Level I* is final when this Section is completed.

II. PROCEDURE: The first step is to obtain sufficient information and/or documentation to be able to answer the eight (8) questions on the PASARR *Level I* form. The decision of whether or not a *Level II* assessment is required is based on these answers.

NOTE: When it is unclear whether or not a Level II assessment is required, and a judgment call is made to NOT refer for a Level II, write a concise clear note on the Level I form itself giving a brief explanation of the reason a Level II was not triggered.

Answer the eight (8) questions on the *Level I* in the following order:

Step 1: Answer Question #1 last.

Step 2: Answer Questions #2 - #8. (See Section III of this protocol for additional information on each question.)

Step 3: If any Question #6 - #8 is answered "Yes," the "dementia exclusion" does ***NOT*** apply and a PASARR/DD Level II ***MUST*** always be required.

Step 4: If Question #2 and/or #3 is answered "Yes," determine whether the diagnosis(es) or condition is "primary/principle." This will affect a "dementia exclusion" decision.

Step 5: Return to Question #1 which is a three-part question. (See Section III. F. of this Protocol for more information.)

Step 6: Make a decision of need for referral for ***Level II*** assessment based on responses to the eight (8) questions on the ***Level I***.

Certify the finding on the bottom of the ***Level I*** form in the section titled, *"Certification of Level II Referral."* For PAS, the IPAS agency must make the certification; for ARR, the NF must certify. ***NOTE: every completed Level I form must have the certification.***

III. ADDITIONAL INFORMATION:

This section provides expanded instructions and directions on how to answer each question on the ***Level I***. It is divided according to the sequence of Questions #2 through #8, with a discussion of Question #1 at the end.

A. DEFERRAL OR DELAY OF LEVEL II ASSESSMENT

A decision may be made that: (a) The need for PASARR Level II assessment can not be determined at this time; or that: (b) Level II is needed but, due to the individual's current condition, results would not be indicative of the ongoing condition.

1. ***DEPRESSION:*** The first situation would exist when a diagnosis of depression appears to reflect a temporary, non-severe condition which would not require Level II. However, if the individual's mood or behavior does not improve or becomes more severe, Level II must be triggered at a later time. (See discussion of "depression" in this Protocol.)

2. ***DELIRIUM:*** The second situation most often occurs when an individual has delirium at the time of referral for Level II. An individual's condition cannot be assessed while delirium is the presenting problem, and Level II must be delayed until the delirium has cleared sufficiently for a Level II to be done.

When either situation exists at the time the Level I is completed and the decision to defer or delay Level II is made, the responsible entity (IPAS agency or NF) must clearly note the finding at the bottom of the Level I. The notation must clearly state that an ***admitting or retaining NF*** is responsible to monitor the individual's condition and make referral for Level II as soon as indicated.

B. Questions #2 and #3: DIAGNOSIS OF MAJOR MENTAL ILLNESS

1. Remember that PASARR/MI is a screen for serious mental illness limited to the major mental illness listed on the Level I form.

   Question #3 is provided to allow space to write in those diagnoses which do not fit the listing in Question #2, but which are unclear or questionable. If Question #3 is checked "Yes," the diagnoses in question should be written in the space following the question. If one is not there, the IPAS agency or NF person certifying need for Level II at the bottom of the Level I form must ascertain why "Yes" was checked and enter the information.

   The IPAS agency or NF person responsible for judging the need for Level II must make a decision whether the condition listed qualifies under one of the major mental illness categories in Question #2. This may require additional information and/or consultation with the PASARR/MI Contact Person at the Community Mental Health Center (CMHC).

   If the diagnosis is ***NOT*** in the category of a major mental illness or is not questionable, and if no other indicators are present to indicate the presence of a major mental illness, it is not necessary to trigger a Level II for mental illness. This is an "advanced categorical determination" situation. A note should be made explaining why the "Yes" was determined to not trigger a Level II.

2. ***"DEPRESSION"*** is a major mental illness diagnosis and is covered by the restrictive definition of mental illness.

   There is, however, a difference between someone who may be temporarily "depressed" because of a major life event (e.g., loss of a spouse, admission to a nursing facility, receiving a terminal diagnosis, etc.) and a clinical diagnosis of "depression."

Differentiation can be difficult even for trained mental health professionals because the symptoms may be the same and also because many of the symptoms of depression mimic dementia. The keys to making the decision are ***"INTENSITY"*** and ***"DURATION."***

The following questions may help in making a decision of whether to require a PASARR/MI Level II assessment for depression:

- ✓ If the individual is having suicidal thoughts, has talked about suicide, or has attempted suicide, trigger a Level II.

- ✓ If the individual is exhibiting a depressed mood or loss of interest or pleasure in all, or almost all, activities of daily living (ADLs) and has symptoms such as loss of appetite, weight loss, sleep disturbance, decreased energy, feelings of worthlessness, excessive or inappropriate guilt, etc., ***suspect depression***.

Look at the ***intensity and duration***, and address the following questions:

- ✓ Do these symptoms represent a change in the person's previous condition and are they persistent; that is, do they occur for most of the day, nearly every day, over an extended period of time (at least 90 days)?

- ✓ Are the symptoms coinciding with a life crisis or drastic change in living arrangement? If the answer is "Yes," and the individual does not have a diagnosis of depression, a Level II is probably not required. In making your final decision, look at the duration of the symptoms. Trigger a Level II in this situation only if the duration is more than 90 days.

NOTE: The IPAS agency may use the "Depression Screen" to identify and document judgments of depression. When used, it becomes part of the permanent case record.

C. ***Questions #4a and #4b: PAST HISTORY OF MI and USE OF MAJOR TRANQUILIZER***

1. ***"PAST HISTORY OF MI:"*** Is there an indication that within the last two (2) years the person has had a serious mental illness diagnosis, been in a state hospital, been a client of a CMHC, etc.? If "Yes," try to get enough information to help you make an informed decision. For example, someone who had been in an inpatient unit twice in the past year would probably trigger a Level II, but an individual who was a mental health center client by

virtue of being in a widow's support group probably would not.

NOTE: Indiana's PASARR/MI program requires full Level II assessment for all PAS applicants seeking admission to a NF who reside in or have a recent past history of residence in a state psychiatric hospital, regardless of the responses on the Level I or claim of a dementia condition, PRIOR to NF admission.

2. ***"USE OF MAJOR TRANQUILIZER:"*** The key to the question of medication usage is what the medication is prescribed for? Is it a major psychotropic or psychoactive medication? What is the amount and frequency of dosage?

   a. ***Why is the medication being prescribed?*** If Question #4b would be the only "Yes" answer in Questions #2-5, attempt to determine the purpose of the medication. Medication for a major mental illness would trigger a Level II.

      Medication for a non-major mental illness, to help with sleep, to calm someone who has just lost a loved one or received a terminal illness diagnosis, etc., would not usually require Level II assessment. (See section on "Depression.") Similarly, medication used to calm agitation or reduce discomfort in a Dementia condition would not trigger a Level II.

      Be suspicious if medications are prescribed, but there is no justification for them. If the justification can not be obtained through other information in the packet or a telephone call to whomever filled out the Level I, then trigger a Level II. This could be a case of trying to mask a major mental illness with medication to avoid the assessment. It is the option of the person responsible for certifying Level II need whether or not to require to see documentation.

   b. ***Is it a major psychotropic or psychoactive medication?*** Make a judgment concerning the seriousness of the medication in question. A guide is the "Psychotropic Medication List" in the IPAS/PASARR Program Manual. It may also be necessary to consult with the local CMHC PASARR contact person or, as a last resort, contact the PASARR/MI Program Specialist in the Bureau of Aging and In-Home Services, DDARS, at 317/232-7947. Document the finding.

   c. ***What is the amount and frequency of dosage?*** Look at whether the amount of medication is significant and how often it is to be taken. Do these factors coincide with the stated

reason for the prescription? Is it a minor dosage given prn? Document the finding.

When sufficient documentation as defined above is entered on the Level I form, check "No" for question #4b.

D. ***Question #5: DISTURBANCES IN ORIENTATION, AFFECT, OR MOOD***

A "Yes" answer would raise the question of what is the presenting evidence and is it related to a medical condition, a non-major mental illness condition, or an irreversible dementing condition. If the behaviors are related to such conditions, a Level II should not be triggered. This is an area where the differentiation between "situational depression" and clinical depression may surface. Document situation with a brief notation.

E. ***Questions #6 - #8: Mental Retardation/Developmental Disability***

The procedure for responding to these questions has not changed. Any questions relating to this condition should be addressed to the local BDDS Field Office or, as a last resort, to the PASARR/DD Program Specialist in the Bureau of Aging and In-Home Services, DDARS, at the State (317/232-7947).

If you received a decision that an individual is **NOT DD**, record the finding of "Not DD" on the Level I, listing the name and affiliation of the BDDS IFS staff person who provided this information (or obtain a copy of the BDDS certification). Continue the process for Level II only if it appears likely that the individual has a major mental illness condition. If so, a PASARR/MI Level II will be required.

F. ***Summary of Questions#2 - #8***

1. If all answers on Questions #2 - #8 are "No," or questionable answers on Questions #2 - #5 have been adequately explained on the Level I form to substantiate a "No" response, Level II is not necessary.

2. If any Question #6 - #8 have been marked "Yes," regardless of the answers on other questions, the PASARR/DD Level II must be required.

3. If any Question #2 - #5 has been answered "Yes," or a questionable "No" response has not been adequately explained away and should be "Yes," proceed to the consideration of ***Dementia*** before triggering a PASARR/MI Level II.

G. ***Question #1: DEMENTIA***

If a PASARR/MI Level II appears necessary at this point, return to Question #1.

Question #1 (Dementia) is ***not a trigger*** for a PASARR/MI Level II.

A condition of dementia (primary or non-primary) may, however, exclude the individual from a PASARR/MI Level II. **NOTE: This exclusion does not apply if the individual also has a primary diagnosis of a major mental illness (MI) and/or is mentally retarded/developmenally disabled (MR/DD).**

Question #1 is a three-part question which should be answered by considering each part as follows:

- ✓ Does the individual have a documentable diagnosis of dementia, including Alzheimer's Disease or a related disorder?
- ✓ Does the individual have a concurrent diagnosis of a major mental illness?
- ✓ Does the individual have a concurrent diagnosis of mental retardation or developmental disability?

NOTE: Refer to the chart on page 2 of this protocol.

1. ***Dementia is not a trigger for a PASARR/MI Level II.*** If no indicators of a major mental illness are also present, either on the Level I or other available information (IPAS packet), a Level II is ***not required*** regardless of the answer to Question #1.

2. If there are indicators of a major mental illness present ("Yes" answer to any Question #2 - #5), and the ***dementia exclusion*** is being applied (a "Yes" answer to Question #1), it is not the PAS agencies' nor the PASARR program's responsibility to approve the dementia documentation. Nursing Facilities should be advised that if they claim the dementia exclusion, now or in the future (PASARR Annual Resident Review), it is ***the NF's responsibility*** to have the diagnosis adequately documented in the patient's medical record. The Dementia Assessment Checklist is a good guideline that may be used to assure adequate documentation. Federal and State surveyors and reviewers will hold facilities accountable for adequate documentation if the exclusion is claimed.

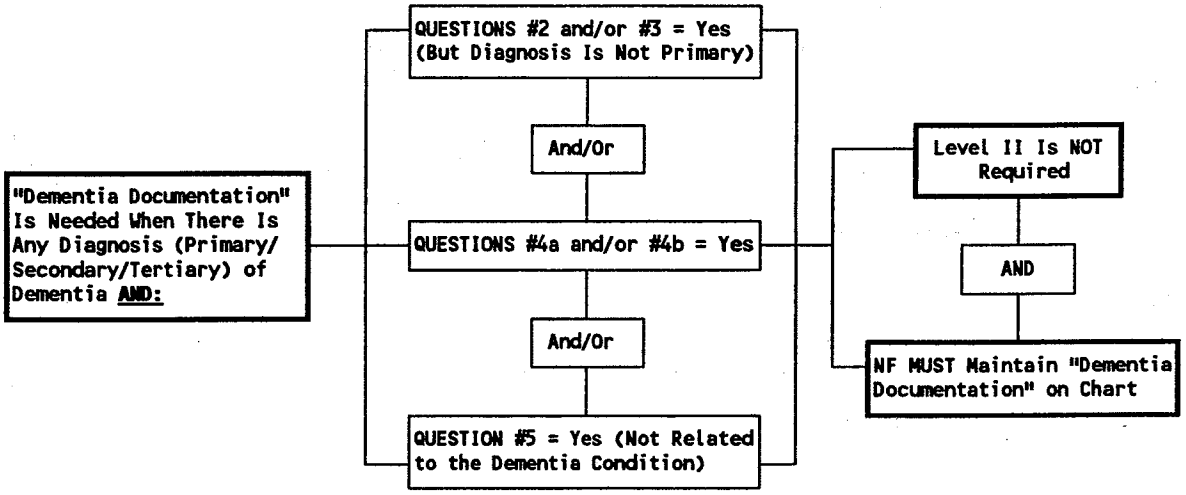
3. PAS agencies do have the authority to request to see the dementia documentation if they feel it is necessary. Normally this should only be done if they suspect that the diagnosis is not valid and is being used solely to avoid the PASARR process. For example, if a review of the PAS packet indicates that the individual has a history of inpatient psychiatric care for schizophrenia with no previous mention of dementia until a nursing home placement was being sought, there is reason for suspicion. One approach would be to contact the hospital or doctor for further information. Previous experience with the individual or facility should also guide the IPAS agency as to whether there is a need to actually physically see the documentation.

What is the "Dementia Exclusion?" When there is any diagnosis of dementia - and there is not also a primary/principle mental illness diagnosis, a Level II is ***NOT*** required. However, the diagnosis of dementia may need to be documented and the dementia documentation kept on the person's chart.

When must the dementia diagnosis be documented? When there is a diagnosis of dementia - and also any indicator of a "non-primary" mental illness in Questions #2 - #5 which would have triggered a Level II in the absence of the Dementia Exclusion provision, the NF will use the Dementia Exclusion and maintain documentation of how the diagnosis of dementia was obtained.

How is dementia "documented?" Ordinarily a dementia diagnosis is based on criteria specified in the current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders, supported by a thorough mental status assessment based on cognitive factors and a comprehensive history and physical examination (H&P) which rules out other causes of the dementia. The "Dementia Assessment Checklist" is a convenient, recognizable format for documenting dementia diagnoses.

Need for Dementia Documentation



H. After completion of all Steps above, if a Level II is still required, continue n to consideration of the categorical determinations for Exempt Hospital Discharge, Respite Care or APS to determine if any of these criteria are appropriate.

I. Make the final decision based on all available information and document on the bottom of the Level I form your certification of need for Level II as previously instructed.

J. Refer for Level II assessment; or, if not necessary, process as a regular PAS or ARR case. The completed Level I becomes part of the permanent case record.

(SHORT FORMAT)

DMH Issued 10/22/91
CSW #9 2/92

PASARR/MI LEVEL I
DECISION MAKING PROTOCOL

STEP I: Complete Level I.

STEP II: Review Level I.

1. Question #1 (Dementia) is not an indicator for a PASARR/MI Level II. **DO NOT** consider the answer to Question #1 at this point. Proceed to Question #2 on the Level I.
2. Review answers to Questions #2-#8. **If all answers are NO, a Level II is not required.**
3. Items for consideration:
   - A. Questions #2 and #3. Remember that PASARR/MI is a screen for serious mental illness limited to the 5 major mental illnesses listed. If Question #3 lists a diagnosis that is not a serious mental illness, it is not necessary to trigger a Level II.

     Depression is a major mental illness diagnosis and is covered by the restrictive definition of mental illness. (See long version of Level I Protocol for information on when to initiate Level II due to depression.)
   - B. Question #4. This is a 2-part question intended to identify factors which, in the absence of a positive response to the other questions, indicate the possible presence of a serious mental illness.

     1) History of mental illness: Consider residence in a state hospital, provision of psychiatric services, etc. If yes, consider nature of services. For example, someone who had been in an inpatient unit in the past year would probably require a Level II, but an individual who was a mental health center client by virtue of being in a widow support group probably would not.

     2) Prescription of a major psychoactive medication: If this is the only "Yes" answer, determine the purpose of the medication. **Write the purpose by Question #4 on the Level I.** If given for a major mental illness, get a Level II. However, medication for a non-major mental illness, to calm agitation or reduce discomfort in a Dementia condition, for sleep, etc., would not trigger a Level II. If medications are prescribed, but there is no justification for them or it can not be obtained, initiate a Level II.
   - C. Question #5. Consider the nature of the presenting evidence and its relation to a medical condition, a non-major mental illness, or an irreversible dementing condition. Behaviors related to these conditions will not trigger a Level II. **An explanation should be written near Question #5 on the Level I. Otherwise, a Level II may be required.**
   - D. Questions #6 - #8. Procedures have not changed. If you have a question on these, contact the area client services office.
   - E. **If all answers on questions #2 - #8 are "No", or "Yes" answers on Questions #2 - #5 have been adequately explained and #6 - #8 are "No," a Level II is not necessary.**
   - F. If a Level II appears necessary at this point, return to Question #1. A diagnosis of dementia (primary or non-primary) may exclude the individual from Level II. However, the exclusion does not apply if the individual has a primary diagnosis of a major mental illness and/or is developmentally disabled/mentally retarded.
     1. **NOTE: Dementia by itself is not a trigger for a Level II. If neither Level I nor other information indicates the presence of a serious mental illness, a Level II is not required regardless of the answer to Question #1.**
     2. **If there are indicators of a non-primary condition of a major mental illness present and a "Yes" answer to Question #1, the nursing facility is responsible to adequately document the dementia in the person's active record and have it available for Federal and State surveyors.**
   - G. If PASARR/MI Level II is indicated, notify the PAS Agency for PAS and DMH for ARR according to established procedures.

IF YOU HAVE QUESTIONS ON THE LEVEL I PROTOCOL OR WANT A COPY OF THE LONG VERSION, CONTACT YOUR LOCAL PAS AGENCY.

Definitions of

MENTAL RETARDATION/DEVELOPMENTAL DISABILITY

and

SPECIALIZED SERVICES

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: INDIANA

DEFINITION OF SPECIALIZED SERVICES

Specialized services are those services identified through the Level II Assessment which are required to address the identified needs related to the person's developmental disability and/or mental illness. These services are not typically provided within or by a nursing facility due to the duration and/or intensity of the services. Specialized services include, but are not limited to, short-term inpatient psychiatric care, long-term inpatient psychiatric care, supported employment, supported employment follow along, sheltered work, vocational evaluation, work adjustment training, vocational skills training and job placement.

INDIANA'S DEFINITION OF DEVELOPMENTAL DISABILITY:

A person with a developmental disability has a severe, chronic disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or a condition, other than mental illness, closely related to mental retardation in that the impairment of general intellectual functioning or adaptive behavior is similar to that of mental retardation. The condition is manifested prior to age 22, is likely to continue indefinitely, and requires the person to have 24 hour supervision. As a result of the condition, the person has subtantial functional limitations in three or more of the following major life areas: self care, understanding and use of language, learning, mobility, self direction and/or capacity for independent living.

D

HOSPITAL–BASED NF UNITS
IPAS/PASARR Program Participation Criteria Worksheet

IPAS Agency _____

(CHART–HO.SP/CSW/6–95)

A. Identify Hospital–Based NF Unit:	B. Licensure Under:		C. Medicaid Certified:			D. Admissions Require:		E. Discharges Require:		
	NF	HOSP								
Name/Address/City	IC–16–28–2	IC–16–21–2	Yes	No	Pending	IPAS	PASARR	IPAS	PASARR	Notes:
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
11.										
12.										
13.										
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15.										

INSTRUCTIONS

HOSPITAL-BASED NF UNITS
IPAS/PASARR Program Participation Criteria Worksheet

PURPOSE: To provide an easy decision-making format for IPAS agencies. This Worksheet will record the status of each hospital-based NF or sub-acute care unit (Extended Care Facility/ECF, Transitional Care Unit/TCU, Essential Care Bed, etc.) in an IPAS agency's catchment area in Columns B and C. Based on these findings, admission requirements for each Unit are recorded in Column D and discharge requirements are recorded in Column E.

A. ***Identify Hospital-Based NF Unit.*** Record the name and address of each hospital-based NF or sub-acute care unit.

B. ***Licensure Under.*** Identify licensure status under the Indiana Code (IC). Enter "Y" in the appropriate Column, and "N" in the other.

1. IC 16-28-2 (formerly IC 16-10-4 through Health Facilities Division); **OR**
2. IC 12-16-28 (formerly IC 16-10-1 through the Hospital Division).

NOTE: Licensure status can easily be checked by referring to the "Long-Term Care Directory" published by the Indiana State Department of Health (IDOH). It lists all NF facilities/beds licensed in Indiana. The first (and largest) Section lists all NFs licensed under IC 16-28-2 by the Division of Long-Term Care (formerly Health Facilities). At the back of the Directory is a Section which lists all NF units/beds licensed under IC 12-16-28 by the Division of Acute Care Services (formerly the Hospital Division). If a unit is newly created and not listed in this Directory, the appropriate division at IDOH should be contacted to obtain licensure status.

C. ***Medicaid Certified.*** Identify Medicaid certification status. This information should be readily available from the Hospital-based NF unit. Complete one (1) column only.

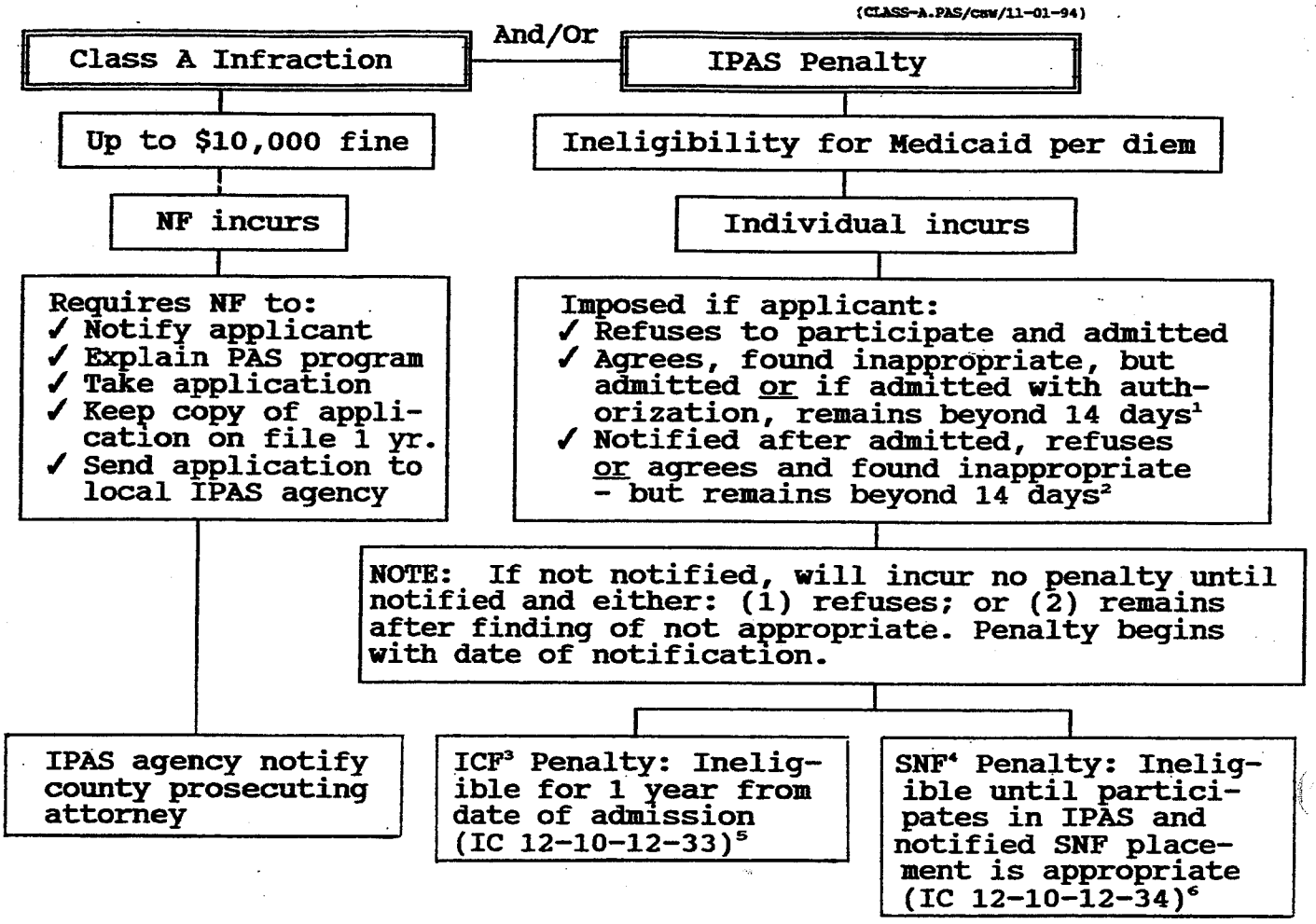
Place a check-mark in the appropriate column: "Y" for a unit which is Medicaid certified; "N" for one which is not; and the approximate date of application for Medicaid certification in "Pending" for a unit which has applied, but not yet received approval. This column should be updated when Medicaid certification is awarded.

D. ***Admissions Require.*** Based on the findings in Columns B and/or C, determine whether individuals admitted to the hospital-based NF unit are required to participate in IPAS and/or PASARR. Insert a "Y" for "yes" and/or an "N" for "no" in each subcolumn.

E. ***Discharges Require.*** Based on the findings in Columns B and/or C, determine whether discharges must participate in IPAS and/or PASARR prior to discharge into a community-based NF. Follow directions in #D, above.

NOTE: If IPAS and/or PASARR are not required for admission, participation will be required prior to discharge. Follow IPAS/PASARR program procedures.

column is provided for "Notes" as needed by the IPAS agency. Once completed, place this chart in a readily accesssible spot for easy reference.



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[1] *460 IAC 1-1-14(b): Allows 14 days for NF discharge planning for person temporarily admitted to NF under designee authorization whose placement is determined to be inappropriate.*

[2] *An individual not notified of the IPAS requirement will incur no penalty, unless the individual refuses to be screened after notification or is found to be inappropriate for NF services, in which case the individual will incur the penalty beginning with the date of notification that PAS is required. [460 IAC 1-1-14(d)]*

[3] *Refers to intermediate (I) care in a NF.*

[4] *Refers to skilled (S) care in a NF.*

[5] *Admission: A person is admitted to a NF as soon as that individual is physically present in the NF, unless the admittance is designee-approved. A person approved by a designee is considered admitted twenty-four (24) hours after entering the NF. (460 IAC 1-1-2) The time of the IPAS penalty will be computed to include the period of authorization, but will not be imposed for such designee authorized time. [[460 IAC 1-1-14(c)]*

[6] *IC 12-10-12-34 allows an individual residing in a skilled NF, who refused IPAS at NF admission, to decide to agree and be IPAS assessed. If skilled NF placement is determined to be appropriate, the remainder of the IPAS penalty will be lifted effective when the individual receives the determination. In no case will the IPAS penalty last more than one (1) year from the date of NF admission. [460 IAC 1-1-14(c)]*

PASRR/MI PROGRAM:
DEFINITIONS OF MENTAL ILLNESS AND SPECIALIZED SERVICES

C

3RR FEDERAL RULES AND REGULATIONS (November 30, 1992): Effective January 29, 1993
Section 483.102(b) Definition of PASRR/MI Mental Illness (MI)

An individual is considered to have a serious mental illness (MI) if the individual meets the following requirements:

A. **DIAGNOSIS:**

1. Has a diagnosis of schizophrenic, mood paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability;
2. Does not have a primary diagnosis of dementia, including Alzheimer's disease or a related disorder;
3. Does not have a non-primary diagnosis of dementia unless the primary diagnosis is a major mental illness as defined in number 1, above.

AND

B. **LEVEL OF IMPAIRMENT:** Within the past 3 to 6 months, the disorder results in functional limitations in major life activities that would be appropriate for the individual's developmental stage.

At least one of the following characteristics is present on a continuing or intermittent basis:

1. **Interpersonal functioning:** serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation; **OR**
2. **Concentration, persistence, and pace:** Serious difficulty in sustaining focussed attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks; **OR**
3. **Adaptation to change:** serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.

C. **RECENT TREATMENT:** treatment history indicates at least one of the following:

1. **Psychiatric treatment** more intensive than outpatient care more than once in the past 2 years (e.g., partial hospitalization or inpatient hospitalization);
   OR
2. Within the last 2 years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

Section 42 CFR 483.120(a) Definition of PASRR/MI SPECIALIZED SERVICES (SS)

I. **DEFINITION OF MI SPECIALIZED SERVICES** (Indiana Medicaid State Plan)

For PASRR/MI purposes, Specialized Services are defined as the implementation of an individualized plan of care developed under and supervised by a physician, provided by a physician and other mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of severe mental illness, which necessitates supervision by trained mental health personnel. A nursing facility resident with mental illness who requires specialized services shall be considered to be eligible for the level of services provided in an institution for mental diseases (IMD) or an inpatient psychiatric hospital (subject to Medicaid reimbursement requirements).

II. **DEFINITION OF SPECIALIZED SERVICES** [42 CFR 483.120(a)]

(I) For mental illness, specialized services means the services specified by the State which, combined with services provided by the NF, results in the continuous and aggressive implementation of an individualized plan of care that-

- **(i)** Is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professionals and, as appropriate, other professionals;
- **(ii)** Prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness, which necessitates supervision by trained mental health personnel; and
- **(iii)** Is directed toward diagnosing and reducing the resident's behavioral symptoms that necessitated institutionalization, improving his or her level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

I

PASARR/MI LEVEL II

DEFINITIONS/DESCRIPTIONS OF *MENTAL HEALTH SERVICE NEEDS*

A Level II Mental Health Assessment done under the PASARR/MI program will usually recommend certain specific mental health services for each individual assessed. The nursing facility and the individual's physician must review these recommendations and provide for them in the the individual's plan of care. The following discussion of the most often recommended services will explain the scope and intent of these recommendations.

Medication Review/Adjustment: When this service is listed, there is a need to review the psychoactive medications of the resident as soon as possible or, when indicated, within a specific time interval. A reason for such review may or may not be specified. Usually, however, the implied reason is that a psychoactive medication should not be administered over a long period of time without evaluating its effect and determinaing whether the medication can be decreased or discontinued. The patient's physician may choose to perform this review or make referral to a psychiatrist.

Mediction Monitoring: Nursing facility staff should continually monitor the patient for any side effects or symptoms of an illness that the prescribed medication is intended to control and report any occurrences. As OBRA '87 has imposed very strict guidelines on nursing facilities to monitor all medications, this recommendation is no longer being routinely made as a result of Level II assessments for persons residing in nursing facilities.

However, persons who are not expected to enter a nursing facility (and will instead be placed in a residential level of care facility or will remain at home and receive services) should arrange to have psychoactive medications reviewed and tracked regularly on an out-patient basis.

Periodic Assessment of Psychiatric Condition: Although this recommendation is not listed on the Level II evaluation form as a recommended service, it has been reoutinely included on final determinations of the Level II process (on the Form 4B for PreAdmission Screening and on the Final Determination Letter for Annual Resident Review.)

The intent is to emphasize the existence of a psychiatric condition, which may or may not be included in the list of diagnoses on record, that would require routine documentation as a part of the treatment plan. This documentation is performed by appropriate disciplines within the nursing facility staff.

With the required documentation of all conditions particular to a nursing facility resident under OBRA '87, and especially with the appropriate use of the Minimum Data Set instrument, this recommendation is no longer being made

for nursing facility residents as a Level II recommendation.

When this service recommendation is made for non-nursing facility residents, a case management follow up probably better describes the recommended service and will be so stated in future detereminations.

Medications Administered: For persons not expected to be placed in a nursing facility, there is an awareness that assistance is needed for administration of medications, either due to physical limitations or a history of non-compliance.

Individual/Group Counseling: A general or specific form of counselling may be recommended. It may be performed by qualified nursing facility staff or may be referred to a mental health provider. If there is a question as to what type of counselling is recommended when it is not specified, inquiry may be made to the assessor listed on page 1 of the Level II evaluation form.

Partial/Day Treatment: This is a service provided by each Community Mental Health Center that is intended to avoid the need for in-patient psychiatric treatment. Factors such as distance, finanacial arrangements, and compliance may need to be considered to make this therapy feasible. If not feasible, an alternative therapy may be proposed. It is recommended that inquiry with the CMHC servicing the area of the facility be made.

Case Management Follow-along: Under this service, referral to a mental health provider is indicated for one or more services for continuous monitoring of a condition. The provider may consider, for example, the need for medication review and monitoring, counselling visits and a therapy program involving significant others. The provider would manage a person's mental health needs on a time table or as need arises. Inquiry should be made with the assessor listed on page 1 of the Level II evaluation form for more detail when this is a recommendation.

Diagnosis Review/Update: A review of diagnosis may be indicated for either of two reasons: 1) a discrepancy may exist between the diagnosis on record and a condition that is currently being found; or 2) the current diagnosis is expected to improve, in which case another diagnosis or no diagnosis could be the finding at a later date. The person's physician may choose to perform a review/update or make referral to a psychiatrist. A psychiatric diagnosis which no longer exists should be removed from the list of current diagnoses on record.

Needs Further Review: A psychaitric condition may be suspected, but can not be diagnosed by the time the Level II assessment must be submitted. The nursing facility or the individual's physician should arrange to have a psychiatric consultation to complete the diagnostic process and prescribe appropriate treatment.

It is expected that all recommendations resulting from the PASARR/MI Level II assesment process will be provided to the person's primary care physician and, when the person is also followed by a psychiatrist, the specific psychiatrist. All action on these recommendations should be documented in the nursing facility record, whether

the services are obtained or not. If services are not obtained, document the reason why these were not followed through or obtainable.

For questions regarding the specificity of a recommendation to a particular person, please contact the Level Ii assessor who performed the assessment, listed near the top of page 1 of the Level II form. Contact the same person if information is needed on how to obtain services.

INDIANA PASARR PROGRAM
DEMENTIA ASSESSMENT CHECKLIST

State Form 47182 (9-95) / BAIS 0029

This form shall become a **CONFIDENTIAL RECORD** upon completion in accordance with 42 CFR 483.100 et. al.

* This State agency is requesting disclosure of your Social Security number, under 42 CFR 483.100 et. al. Disclosure is voluntary, and you will not be penalized for refusal.

Name of applicant / resident	Social Security number *	Date of birth

Name of nursing facility	Telephone number

Address (*number and street, city, state, ZIP code*)

DEMENTIA ASSESSMENT CHECKLIST

Federal PASARR regulations require documentation of a diagnosis of dementia (*including Alzheimers Disease and related disorders*) if an individual is excluded from PASARR / MI Level II assessment based on the dementia exclusion. An individual with a primary / principal diagnosis of a major mental illness (MI) or who is developmentally disabled (MR/DD) may not be excluded. To document the dementia diagnosis, the sections of this form may be completed or other documents which address the criteria in Sections 1-5 may be obtained. This documentation must be retained on the individual's active record in the NF. The purpose is to minimize the risk of overlooking potentially reversible conditions that may be causing or mimicking dementia.

If this form is used, ALL sections must be completed. At a minimum, the physician must sign and date the form. If sections are completed by different persons, the person completing it must also sign and date that part. Information must be current in that the patient's condition has not changed since testing results were obtained. Information may be obtained from the phyisican's current records, hospital summaries, etc.

NOTE: The nursing facility is responsible to maintain on file acceptable documentation of dementia for any person for whom the exclusion is claimed.

1. DSM-IV Criteria: For dementia, all areas must be checked "Yes".

- ☐ Yes ☐ No A. Evidence of short-term and long-term memory loss.
- B. One or more of the following:
- ☐ Yes ☐ No 1. Impaired abstract thinking;
- ☐ Yes ☐ No 2. Impaired judgement;
- ☐ Yes ☐ No 3. Other higher cortical dysfunction (*e.g. aphasia, apraxia, agnosia, constructional dyspraxia*).
- ☐ Yes ☐ No C. A & B significantly interferes with work or usual activity.
- ☐ Yes ☐ No D. Not occurring exclusively during the course of delirium.
- ☐ Yes ☐ No E. Insidious onset with generally progressive deterioriating course.
- ☐ Yes ☐ No F. Exclusion of other specific causes of dementia by histc physical and laboratory tests. (*See sections 2-4 below.*

2. Mental Status Examination: At least one must be checked. Enter results and interpretation. Attach an additional page if needed.

- ☐ Short Portable Mental Status Questionnaire (SPMSQ) Score: _____/_____ errors
- ☐ Folstein Mini Mental Status Exam Score: _____/_____ errors
- ☐ Halstead-Reitan, Luria Nebraska or other neuropsychological assessment battery _____
- ☐ CAMCOG-Cambridge Cognitive Examination portion of CAMDEX Score: _____ errors
- ☐ Kahn-Goldfarb MSQ; Face-Hand Test Score: MSQ _____ errors
  FHT _____ errors
- ☐ CBRS-Cognitive Behavior Rating Scale Score: _____
- ☐ Mattis Dementia Rating Scale Score: _____
- ☐ Blessed Dementia Scale Score: _____
- ☐ Wechsler Tests (WAIS-R or WMS-R) Scores: _____
  _____ _____
- ☐ Other: _____ Score: _____

Interpretation(s):

Testing by: (*If Mental Status Exam done by someone other than the physician*)	Date (*month, day, year*)

Affiliation:	Credentials

(*Continued on the reverse side*)

DEMENTIA ASSESSMENT CHECKLIST (*Continued*)

3. MEDICAL PROCEDURES: Screening and laboratory procedures performed to either substantiate dementia or to rule out other possible causes of dementia. (*Check all that have been completed and reviewed.*)

- ☐ Medication Review to rule out medication effects
- ☐ Vision / hearing problems
- ☐ Environmental change
- ☐ Assessment for depression and other psychiatric disorders
- ☐ Brain trauma / concussion
- ☐ ASHD / CHF / Alcoholism / Anemia / etc.
- ☐ Thyroid Function
- ☐ Urinalysis
- ☐ Electrolyte Panel
- ☐ Screening Metabolic Panel
- ☐ B12 and Folate Levels
- ☐ Chest Xray
- ☐ Electrocardiogram
- ☐ Other: _____
- ☐ CBC
- ☐ CT Scan *
- ☐ MRI *
- ☐ EEG *
- ☐ PET *
- ☐ Biopsy *

Results / interpretation:

* Not required. Record results if completed for purposes other than completion of this form.

4. PATIENT / FAMILY HISTORY: As complete a history as possible should be obtained to supplement the detection of occult medical illness in number 3 above: (*NOTE: May be provided by family or other responsible party.*)

5. OTHER PROCEDURES used to substantiate diagnosis or to rule out possible causes of dementia: (*Indicate "None" if applicable.*)
Procedure(s):

Interpretation:

6. In your best judgment, is the dementia condition expected to be reversible, e.g., dementia following surgery, due to hypothyroidism, etc.? Or is it irreversible and anticipated to worsen?

☐ REVERSIBLE ☐ IRREVERSIBLE Comments: _____

If reversible, the NF should monitor and assure necessary services are provided for the individual's recovery.

7. Does the person have behavior problems?	Is the person a danger to self or others?
☐ Yes ☐ No	☐ Yes ☐ No

If Yes to number 7: Explain, including recommended strategies to deal with problems.

Information completed by (*If other than the physician*):

Name	Date (*month, day, year*)
Affiliation	Credentials

This documentation must be certified by the physician:

Signature of physician	Printed name of physician	Date (*month, day, year*)

PASRR LEVEL I - IDENTIFICATION EVALUATION CRITERIA
CERTIFICATION BY PHYSICIAN FOR LONG-TERM CARE SERVICES

State Form 45277 (R2 / 7-02) / Form 450B/PASRR2A - Sections IV and V, Part A

This form is **CONFIDENTIAL** according to IC12-15-2 *et seq.*, IC 12-10-10 *et.seq.*, IC 12-21 and 470 IAC 1-3-1.

This form **MUST** be completed for **ALL** persons prior to nursing facility admission in accordance with 42 CFR 483.106. All of the following questions must be answered as indicated.

Name of applicant / resident	Name of facility / city

Current location of applicant ☐ Residential ☐ Home ☐ Nursing facility ☐ Psychiatric bed ☐ Acute hospital ☐ Other:

Please check any of the following that applies to the applicant / resident:

☐ New admission ☐ Readmission to NF from psychiatric hospital stay ☐ Transfer between NF's ☐ Out-of-state resident
☐ Transfer from residential to NF ☐ Other: _____

SECTION IV

1. Does the individual have a documentable diagnosis of senile or presenile dementia (*including Alzheimer's Disease or related disorder*) based on criteria in DSM-IV, without a concurrent primary diagnosis of a major mental illness or a diagnosis of mental retardation or developmental disability?	☐ Yes ☐ No
2. Does the individual have a diagnosis of major mental illness *[limited to the following disorders: schizophrenic, schizoaffective, mood (bipolar and major depressive type), paranoid or delusional, panic or other severe anxiety disorder; somatoform or paranoid disorder; personality disorder; atypical psychosis or other psychotic disorder (not otherwise specified); or another mental disorder that may lead to a chronic disability]*?	☐ Yes ☐ No
3. a. Does the person have a diagnosis of mental illness not listed above? List diagnosis: b. Has the individual been prescribed *(within the past 1 year)* a major tranquilizer or psychoactive drug on a regular basis for a mental health condition? *(If given for another purpose, explain by listing the name of the drug and the purpose of the prescription; for example, Mellaril for dementia. When explained and documented in the individual's medical record, check "No".)* ** A Yes answer to 3a and / or 3b DOES NOT ALONE trigger a Level II.*	☐ Yes ☐ No ☐ Yes ☐ No
4. Has the person had any recent (*within the last two years*) history of in patient / partial hospitalization care? Explain:	☐ Yes ☐ No
5. Does the individual have a diagnosis of mental retardation, developmental disability (*MR / DD*) or other related condition?	☐ Yes ☐ No
6. Is there any history of a MR / DD or related condition in the individual's past?	☐ Yes ☐ No
7. Is there any presenting evidence (*cognitive or behavior characteristics*) that may indicate the person has MR / DD or related condition? (*Explain*)	☐ Yes ☐ No

Signature of authorized assessor	Title / Position	Date signed

SECTION V - PART A

PASRR Determination Criteria - Level II Exemption: See back of form for explanation. *(Exemption **MUST** be certified by a physician's signature.)*

NOTE: Exemption applies only to initial nursing facility admission, not to RR or transfers.

EXEMPTED HOSPITAL DISCHARGE: An individual may be admitted to a nursing facility directly from a hospital after receiving acute inpatient care *(non-psychiatric)* at the hospital if: (1) the individual requires nursing facility services for the condition for which he/she received care in the hospital; and (2) the attending physician certifies before the admission that the individual is likely to require less than 30 days nursing facility care.

In accordance with the requirements above, I certify that this individual requires less than 30 days of care in a nursing facility.

Signature of physician	Printed name of physician	Date signed
If applicable, hospital or other affiliation:	City	

NOTE: If the individual requires care beyond the initial 30 day period, the nursing facility must notify the PAS agency prior to the expiration of 30 days and provide a written explanation of the reason continued residence is required and the anticipated length of stay. Admission under the above exemption does not exempt the nursing facility from providing services to an individual who has mental health or MR/DD or related needs and would benefit from services. Refer to II B on back for complete instructions

CERTIFICATION OF LEVEL II REFERRAL

PASARR LEVEL II ASSESSMENT REFERRAL NEEDED	PAS: ☐ Yes ☐ No	
Signature of PAS agency respresentative	Title / Position	Date signed

LEVEL II: PASRR / MI MENTAL HEALTH ASSESSMENT

State Form 47185 (R5 / 4-99) / BAIS 0036

Information contained herein is **CONFIDENTIAL** according to IC 16-14-1.6-8.

Z

PAS (PreAdmission Screening) ☐ New Mental Health Assessment ☐ Updated PAS	Give date of IPAS agency initial referral:	Give date returned to IPAS agency:	Send completed forms to: "LOCAL IPAS AGENCY"
☐ RR (Resident Review): ☐ Yearly RR ☐ Significant - Change RR ☐ "Missed" RR	Prior Level II done: ☐ Yes ☐ No ☐ Unknown If "Yes" complete for most-recent: (1) Check: ☐ PAS ☐ PAS Update ☐ Yearly RR ☐ Significant-Change RR (2) Give date of psychiatrist signature: _____ ☐ "Missed" RR		Send completed RR Check-list with RR Case(s) to: MS21 PASRR / MI Program, Room W454, P.O. Box 7083 Indianapolis, IN 46207-7083

Name of ☐ PAS applicant or ☐ NF resident:	Birthdate (*month, day, year*):	Age:	Sex: ☐ Male ☐ Female
Location where Level II completed (*name, address, city, state, ZIP code*) (*home or include name of facility or hospital*):		If in NF, date of initial admission:	
Name and address of CMHC or hospital completing Level II: *		Date of evaluation (*mo., day, yr.*):	

* This Level II assessment was completed by an entity which is not a nursing facility and has no direct or indirect affiliation with such facility. [P.L. 101-508, Sec. 408 (b)(1-8) and 42 CFR 483.106 (e)(3)]

I. PAS location of applicant (*check all that apply*):

- ☐ At own home / residence
- ☐ In hospital: ☐ Acute Care ☐ Non-Acute Care ☐ Psychiatric ☐ Non-Psychiatric
- ☐ In NF from home: ☐ APS ☐ Respite Stay
- ☐ Continued stay in NF beyond exempted hospital discharge
- ☐ Other: _____

II. Significant - Change RR purpose (*check all that apply*):

- ☐ Change in mental status WITHOUT hospitalization
- ☐ Change in mental status WITH hospitalization
  - ☐ In hospital (*No prior Level II*)
  - ☐ In NF (*Readmitted on basis of current Level II*)
- ☐ Other: _____

III. "Missed Level II": (*check one*) ☐ PAS ☐ Yearly RR ☐ Significant-Change RR		Private - pay: ☐ Yes ☐ No
Social Security number	Medicare number	Medicaid number

I. DRUG HISTORY

The PASRR / MI assessment process must provide a comprehensive drug history, including current and immediate past use of medications with particular attention to use of medications that could mask symptoms or mimic mental illness. [42 CFR 483.134 b(2)] The psychiatrist should review the medications for appropriateness and medication interaction.

LIST ALL CURRENT MEDICATIONS	DOSAGE / FREQUENCY	START DATE	REASON FOR PSYCHOTROPIC MEDICATIONS (*If Unknown, Explain*)

OPTION: Please see attached medication sheet. ☐ Yes ☐ No

SIGNIFICANT - CHANGE RR AND UPDATES ONLY: Reviewed current Level II: ☐ Yes ☐ No Significant changes: ☐ Yes ☐ No

INAPPROPRIATE REFERRAL (*Identified after assessment begun: Stop and complete Inappropriate Referral form.*)

PAST TWELVE MONTHS (*Major Psychotropic Drugs*)	DOSAGE / FREQUENCY	START / STOP DATES	REASON / PURPOSE FOR PSYCHOTROPIC MEDICATIONS

RR AND UPDATES ONLY: Medications reviewed: ☐ Yes ☐ No Any changes since last Level II: ☐ Yes ☐ No

Name of applicant	Social Security number	Date of birth

II. PSYCHOSOCIAL REPORT

The PASARR / MI process must include a psychosocial evaluation of the person, including current living arrangements and medical and support systems. [42 CFR 483.134 (b) (3)]

RENT LIVING ARRANGEMENT (*Brief description*) What has been this person's residence for the last several years? How long has this person lived e nursing facility? What is this person's stated preference of living arrangement? Is it feasible? Explain. Add any other pertinent details deemed appropriate.

SUPPORT SYSTEMS (*Family, friendships, church, associations, etc.*) What emotional support does this person have? How extensive is the support system outside the NF? Where do they live? Who actively supports the person? Explain. For PAS cases, have you contacted the persons listed? Is there a legal guardian? Is the guardianship full or limited? Include names and addresses, if available.

AL SYSTEMS Identify this person's attending physician. (*Other pertinent medical professionals may be entered, as deemed necessary.*)

If the psychological evaluation is not conducted by a social worker, than a social worker's review and concurrence with pages 1 and 2 above is required and must be documented by a co-signature below. [42CFR 483.134 (c)] Specify social worker's credentials: LSW, LCSW, BSW, and / or MSW.

Signature of evaluator	Professional credentials	Date (*month, day, year*)	Telephone number
Co-signature (*if needed*)	Professional credentials	Date (*month, day, year*)	Telephone number

III. PSYCHIATRIC HISTORY AND EVALUATION

The PASARR / MI process must be a comprehensive assessment. At a minimum, this assessment must address the following areas: complete psychiatric history for the past 24 months, including all hospitalizations and / or out-patient episodes; evaluation of intellectual functioning, memory functioning, and orientation; description of current attitudes and overt behavior; affect; suicidal or homicidal ideation; paranoia; and degree of reality testing (*presence and content of delusions*) and hallucinations. (42 CFR 483.134) Attach copies of all available discharge summaries dated within the past 24 months. You may summarize information from records. If unavailable, note and explain.

A. NAME OF TREATMENT LOCATION	DATE OF ADMISSION	DATE OF DISCHARGE	DIAGNOSIS (*Include current DSM code whenever possible*)	DISCHARGE SUMMARY

Is this individual currently receiving mental health services? ☐ Yes ☐ No

If "Yes", specify:

Name of applicant	Social Security number	Date of birth

B. MENTAL STATUS EVALUATION (*"WNL" means within normal limits. Check all box(es) that apply.*)

	WNL	VARIATIONS								
Appearance	☐	☐ Poor Hygiene	☐ Disheveled	☐ Inappropriate	☐ Bizarre	☐ Obese	☐ Thin/Emaciated	☐ Other (*Clarify below*)		
Attitude	☐	☐ Guarded	☐ Suspicious	☐ Uncooperative	☐ Belligerent	☐ Indifferent	☐ Manipulative	☐ Other (*Clarify b*		
Motor Activity	☐	☐ Restless / Agitated	☐ Tremors / Tics	☐ Retarded				☐ Other (*Clarify below*)		
Affect	☐	☐ Constricted	☐ Stunted	☐ Flat	☐ Agitated	☐ Excited		☐ Other (*Clarify below*)		
Mood	☐	☐ Depressed / Sad	☐ Anxious	☐ Elated	☐ Hostile / Angry	☐ Euphoric	☐ Labile	☐ Other (*Clarify below*)		
Speech	☐	☐ Soft ☐ Loud	☐ Rapid ☐ Aphasic	☐ Slowed	☐ Delayed Responses	☐ Slurred	☐ Pressured	☐ Other (*Clarify below*)		
Thought Process	☐	☐ Circumstantial	☐ Tangential	☐ Loose	☐ Flight of Ideas	☐ Delusional	☐ Concrete	☐ Other (*Clarify below*)		
Thought Content	☐	☐ Paranoid	☐ Obsessional	☐ Poverty of Content		☐ Preoccupied with _____				
		☐ Hallucinations:	☐ Auditory	☐ Visual	☐ Other _____					
		☐ Suicidal:	☐ Ideations	☐ Intent	☐ Plans: Comments: _____					
		☐ Homicidal:	☐ Ideations	☐ Intent	☐ Plans: Comments: _____					
Orientation	☐	☐ Place	☐ Person	☐ Time	☐ Passage of Time			☐ Other (*Clarify below*)		
Memory	☐	☐ Recent	☐ Remote	☐ Selective	☐ Immediate			☐ Other (*Clarify below*)		
Judgment	☐	☐ Poor Impulse Control	☐ Questionable	☐ Maladaptive	☐ Co-Dependent			☐ Self-Destructive	☐ Other (*Clarify*)	
Insight	☐	☐ Has some insight	☐ Has very little insight		☐ Insight lacking			☐ Other (*Clarify below*)		
Intellect	☐	☐ Above Average	☐ Below Average		☐ Retarded			☐ Other (*Clarify below*)		
Cognition	☐	☐ Level of Consciousness	☐ Attention Span		☐ Abstract Thinking			☐ Calculation Ability	☐ Other (*Clarify*)	

C. NARRATIVE DESCRIPTION Give a narrative description of this person. Include any pertinent explanations of the MS evaluation checklist, above, or other behavioral problems identified. Additional pages / reports may be attached as needed. Address positive traits, strengths and weaknesses, and emotional needs. [42 CFR 483.128 (i)] **NOTE: This mental status description does not determine need for NF level of services.**

This person's current or past behavior presents a danger to self or others? ☐ Yes ☐ No (*If "Yes", explain.*)

Name of applicant	Social Security number	Date of birth

IV. SUMMARY OF ASSESSMENT FINDINGS

The Level II assessment must result in independent diagnosis(es) by the evaluator, supported by the data entered in the Level II document. When more than one (1) diagnosis is listed, list them by level of intensity with the **principal / primary** diagnosis first, etc. **ENTER CURRENT DSM CODE + DIAGNOSIS FOR EACH IDENTIFIED MI CONDITION.**

AXIS II:

AXIS III: (*From medical records / NF chart*)

AXIS I from chart (optional):

DEFINITION OF "MENTAL ILLNESS": An individual is considered to have mental illness if he / she has a current primary or secondary diagnosis of a major mental disorder (*as defined in the current Diagnostic and Statistical Manual of Mental Disorders*) limited to schizophrenic, schizoaffective, mood (*bipolar and major depressive type*), paranoid or delusional, panic or other severe anxiety disorder; somatoform or paranoid disorder; personality disorder; atypical psychosis or other psychotic disorder (*not otherwise specified*); or another mental disorder that may lead to a chronic disability; and he / she does not have a concurrent predominant (*primary or principal*) diagnosis of senile or presenile dementia (*including Alzheimer's Disease or related disorder*) or any condition determined to be mental retardation / developmental disability (MR / DD). (*See Appendix C of the IPAS / PASARR program manual.*)

A. This individual ☐ **is** ☐ **is not** **mentally ill as defined above.**

DEFINITION OF "MI SPECIALIZED SERVICES": Specialized Services are defined as the implementation of an individualized plan of care developed under and supervised by a physician, provided by a physician and other qualified mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an **acute episode** of severe mental illness, which necessitates supervision by trained MH personnel. A nursing facility resident with mental illness who requires specialized services shall be considered to be eligible for the level of services provided in an institution for mental diseases (IMD) or an inpatient psychiatric hospital (*subject to Medicaid reimbursement requirements*).

B. This individual ☐ **is** ☐ **is not** **in need of mental health specialized services / inpatient psychiatric care (as defined above).**

C. SERVICES OF LESS INTENSITY THAN SPECIALIZED SERVICES: This individual needs the following mental health services, regardless of placement. (42 CFR 483.128) **CHECK ALL THAT APPLY.**

☐ Diagnosis Review / Update by NF / Hospital
☐ Dementia Work-Up
☐ MH Case Management Services
☐ Continue Current MH Services
☐ Yearly RR Required
☐ Psychiatric Evaluation
☐ Outpatient MH Services
☐ Individual / Group Therapy
☐ Partial Hospitalization / Day Treatment
☐ Further Evaluation of Medication Side Effects
☐ Medication Review
☐ Medication Adjustment
☐ Medication Monitoring
☐ Medication Administration
☐ Needs Further Review - Specify: _____
☐ Other - Specify: _____
☐ None of the above-listed services required at this time

Identify placement options which would meet the individual's needs. Check all viable options, regardless of current availability. NOTE: Recommendations do not constitute approval for such placement.
In my opinion, if nursing facility placement is not appropriate, the following option(s) may apply.

☐ State Hospital ☐ Other Residential - Specify: _____
CMHC Residential Program: ☐ Semi-Independent Living ☐ Supervised Group Living ☐ Alternative Family Living Program
☐ Other - Specify: _____

NOTE: The results of this assessment do not determine need for NF level of services.

IF INDIVIDUAL IS IN NF, AVAILABLE RESIDENT ASSESSMENT / MDS WAS REVIEWED: ☐ Yes ☐ No Comments: _____

Assessments are required under the minimum federal criteria for states to use in making preadmission screening and annual resident review determinations about admission to or continued residence in nursing facilities for individuals who have mental illness or mental retardation. (42 CFR 483.100-138)

Signature of Evaluator	Credentials	Date	Telephone number

☐ I certify that I have reviewed the above report and concur with the findings. [42 CFR 483.134 (d)]

Signature of Psychiatrist		Date	Telephone number
	☐ Board certified ☐ Board eligible		

I. FEDERAL RULES AND REGULATIONS (November 30, 1992) : Effective January 29, 1993
Section 483.102 (b) Definition of PASRR / MI Mental Illness (MI)

An individual is considered to have a serious mental illness (MI) if the individual meets the following requirements:
A. **DIAGNOSIS:**
1. Has a diagnosis of schizophrenic, mood paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability;
2. Does not have a primary diagnosis of dementia, including Alzheimer's disease or a related disorder or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental illness as defined in number 1, above.

AND
B. **LEVEL OF IMPAIRMENT:** Within the past 3 to 6 months, the disorder results in functional limitations in major life activities that would be appropriate for the individual's developmental stage.

At least one of the following characteristics is present on a continuing or intermittent basis:
1. **Interpersonal functioning:** serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation;
2. **Concentration, persistence, and pace:** Serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks **AND**
3. **Adaption to change:** serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.

AND
C. **RECENT TREATMENT**: Treatment history indicates at least one of the following:
1. Psychiatric treatment more intensive than outpatient care more than once in the past 2 years (*e.g., partial hospitalization or inpatient hospitalization*); **OR**
2. Within the last 2 years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

II. Definition of PASRR / MI SPECIALIZED SERVICES

A. DEFINITION OF MI SPECIALIZED SERVICES (*Indiana Medicaid State Plan*)
For PASRR / MI purposes, Specialized Services are defined as the implementation of an individualized plan of care developed under and supervised by a physician, provided by a physician and other mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of severe mental illness, which necessitates supervision by trained mental health personnel. A nursing facilty resident with mental illness who requires specialized services shall be considered to be eligible for the level of services provided in an institution for mental diseases (IMD) or an inpatient psychiatric hosptial (*subject to Medicaid reimbursement requirements*).

B. DEFINITION OF SPECIALIZED SERVICES [42 CFR 483.120 (a)]
(1) For mental illness, specialized services means the services specified by the State which, combined with services provided by the NF, results in the continuous and aggressive implementation of an individualized plan of care that -
(i) Is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professionals and, as appropriate, other professionals;
(ii) Prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness, which necessitates supervision by trained mental health personnel; and
(iii) Is directed toward diagnosing and reducing the resident's behavioral symptoms that necessitated insitutionalization, improving his or her level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

I. FEDERAL RULES AND REGULATIONS (November 30, 1992) : Effective January 29, 1993
Section 483.102 (b) Definition of PASRR / MI Mental Illness (MI)

An individual is considered to have a serious mental illness (MI) if the individual meets the following requirements:
A. **DIAGNOSIS:**

Has a diagnosis of schizophrenic, mood paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability;

2. Does not have a primary diagnosis of dementia, including Alzheimer's disease or a related disorder or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental illness as defined in number 1, above.

AND
B. **LEVEL OF IMPAIRMENT:** Within the past 3 to 6 months, the disorder results in functional limitations in major life activities that would be appropriate for the individual's developmental stage.

At least one of the following characteristics is present on a continuing or intermittent basis:

1. **Interpersonal functioning:** serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation;
2. **Concentration, persistence, and pace:** Serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks **AND**
3. **Adaption to change:** serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.

AND
C. **RECENT TREATMENT**: Treatment history indicates at least one of the following:

1. Psychiatric treatment more intensive than outpatient care more than once in the past 2 years (*e.g., partial hospitalization or inpatient hospitalization*); **OR**
2. Within the last 2 years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

II. Definition of PASRR / MI SPECIALIZED SERVICES

A. DEFINITION OF MI SPECIALIZED SERVICES (*Indiana Medicaid State Plan*)
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B. DEFINITION OF SPECIALIZED SERVICES [42 CFR 483.120 (a)]

(1) For mental illness, specialized services means the services specified by the State which, combined with services provided by the NF, results in the continuous and aggressive implementation of an individualized plan of care that -
   (i) Is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professionals and, as appropriate, other professionals;
   (ii) Prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness, which necessitates supervision by trained mental health personnel; and
   (iii) Is directed toward diagnosing and reducing the resident's behavioral symptoms that necessitated insitutionalization, improving his or her level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

INDIANA PASARR PROGRAM
INAPPROPRIATE REFERRAL FOR PASARR / MI LEVEL II

BB

State Form 47180 (9-95) / BAIS 0028

See instructions on the reverse side.

Name of applicant / resident	Social Security number or date of birth	Medicaid number (RID)

Location (*include name of NF or hospital when appropriate*) / Address (*number and street, city, state, ZIP code*)

From CMHC name

Address (*number and street, city, state, ZIP code*)

INSTRUCTIONS: Use this form in lieu of the PASARR / MI Level II Mental Health Assessment when a referral for Level II is found to be inappropriate or Level II needs to be deferred. Clearly indicate the reason(s) below, adding additional information as needed.

SEND THE COMPLETED FORM FOR:

☐ PAS to: Originating / Local IPAS Agency

☐ ARR to:
Check one: ☐ Routine ☐ Non-Routine

PASARR / MI Program, Bureau of Aging / In-Home Services
402 West Washington Street, Room W454
P.O. Box 7083
Indianapolis, IN 46207-7083

On _____ this agency received a request for PASARR / MI Level II assessment of the above-named individual. Based on a review of the referral and / or other information, a Level II assessment is not required at this time because:

☐ 1. Neither answers to question #2 - 5 on the Level I or other information should trigger a Level II assessment. _____

☐ 2. Questions #2 - 5 would trigger a Level II assessment, but the person is excluded from the Level II because there is a diagnosis of dementia (*including Alzheimers Disease and related conditions*) without a primary diagnosis of a major mental illness (MI) or any diagnosis of mental retardation / developmental disability (MR/DD). NOTE: It is the responsibility of the NF to obtain and maintain adequate documentation of the dementia on the NF chart.

☐ 3. ARR not required at this time. The individual was admitted under an exlusion and the PAS-Level II is currently being done.

☐ 4. PASARR / MI Level II assessment was done within the past quarter and no change in mental health condition has occurred. (*At a minimum, give the date of the psychiatrist's signature / determination, Axis I diagnosis (es), and need for specialized services.*)

☐ 5. Records indicate the person is mentally retarded / developmentally disabled (MR /DD) or is dually-diagnosed with MI (MR / DD / MI).

☐ 6. PASARR / MI Level II assessment is deferred until the individual is able to participate in the assessment. (*Explain the reason.*) The NF is responsible to monitor the individual's condition and make a referral to the CMHC when the individual has sufficiently recovered to have a Level II. (*Clearly explain reason for deferral and give any recommendations.*) _____

☐ 7. Death on (*date*) _____

☐ 8. Discharged. Briefly explain: _____

☐ 9. Other: _____

A Level II is not required at this time. If new information becomes available concerning the need for PASARR / MI Level II, or a significant change occurs in the individual's mental status / behavior, referral for a Level II should be made by letter to the CMHC with a brief explanation of the change / additional information.

When completed by the CMHC, this form is in lieu of a PASARR / MI Level II and must be submitted to the State PASARR Unit for review and determination. It must always be made part of the applicable PAS or ARR case and retained on the individual's chart if admitted to a NF. The CMHC should retain a copy for audit purposes. The NF will receive a copy with the final determination packet

Completed by:	Date	Telephone number

Title / Credentials:	Date of referral for Level II: ☐ By IPAS agency ☐ By NF ☐ By hospital

INDIANA PASARR PROGRAM
INAPPROPRIATE REFERRAL FOR PASARR / MI LEVEL II

BB

State Form 47180 (9-95) / BAIS 0028

See instructions on the reverse side.

Name of applicant / resident	Social Security number or date of birth	Medicaid number (RID)

Location (*include name of NF or hospital when appropriate*) / Address (*number and street, city, state, ZIP code*)

From CMHC name

Address (*number and street, city, state, ZIP code*)

INSTRUCTIONS: Use this form in lieu of the PASARR / MI Level II Mental Health Assessment when a referral for Level II is found to be inappropriate or Level II needs to be deferred. Clearly indicate the reason(s) below, adding additional information as needed.

SEND THE COMPLETED FORM FOR:

☐ PAS to: Originating / Local IPAS Agency

☐ ARR to:
Check one: ☐ Routine ☐ Non-Routine

PASARR / MI Program, Bureau of Aging / In-Home Services
402 West Washington Street, Room W454
P.O. Box 7083
Indianapolis, IN 46207-7083

On _____ this agency received a request for PASARR / MI Level II assessment of the above-named individual. Based on a review of the referral and / or other information, a Level II assessment is not required at this time because:

☐ 1. Neither answers to question #2 - 5 on the Level I or other information should trigger a Level II assessment. _____

☐ 2. Questions #2 - 5 would trigger a Level II assessment, but the person is excluded from the Level II because there is a diagnosis of dementia (*including Alzheimers Disease and related conditions*) without a primary diagnosis of a major mental illness (MI) or any diagnosis of mental retardation / developmental disability (MR/DD). NOTE: It is the responsibility of the NF to obtain and maintain adequate documentation of the dementia on the NF chart.

☐ 3. ARR not required at this time. The individual was admitted under an exlusion and the PAS-Level II is currently being done.

☐ 4. PASARR / MI Level II assessment was done within the past quarter and no change in mental health condition has occurred. (*At a minimum, give the date of the psychiatrist's signature / determination, Axis I diagnosis (es), and need for specialized services.*)

☐ 5. Records indicate the person is mentally retarded / developmentally disabled (MR /DD) or is dually-diagnosed with MI (MR / DD / MI).

☐ 6. PASARR / MI Level II assessment is deferred until the individual is able to participate in the assessment. (*Explain the reason.*) The NF is responsible to monitor the individual's condition and make a referral to the CMHC when the individual has sufficiently recovered to have a Level II. (*Clearly explain reason for deferral and give any recommendations.*) _____

☐ 7. Death on (*date*) _____

☐ 8. Discharged. Briefly explain: _____

☐ 9. Other: _____

A Level II is not required at this time. If new information becomes available concerning the need for PASARR / MI Level II, or a significant change occurs in the individual's mental status / behavior, referral for a Level II should be made by letter to the CMHC with a brief explanation of the change / additional information.

When completed by the CMHC, this form is in lieu of a PASARR / MI Level II and must be submitted to the State PASARR Unit for review and determination. It must always be made part of the applicable PAS or ARR case and retained on the individual's chart if admitted to a NF. The CMHC should retain a copy for audit purposes. The NF will receive a copy with the final determination packet

Completed by:	Date	Telephone number
Title / Credentials:	Date of referral for Level II: ☐ By IPAS agency ☐ By NF ☐ By hospital	

INSTRUCTIONS
INAPPROPRIATE REFERRAL FOR PASARR / MI LEVEL II

PURPOSE: This form has been designed to document the decision by the CMHC that referral for PASARR / MI Level II assessment is inappropriate at the time the referral is made. It will:

1. Document the reason for termination of the Level II referral and identify the entity / individual making the determination;
2. Provide notification of the decision to the IPAS agency (*for PAS*) and / or the State PASARR / MI Unit (*for ARR*);
3. Replace the Level II assessment for documentation purposes; and
4. Serve as documentation of CMHC action for reimbursement / audit purposes.

INSTRUCTIONS: Complete the form as follows:

Section 1: Identifying Information:

A. Enter the **full name of applicant (PAS) or resident (ARR)** in the following order: last, first, middle initial.

B. Enter the individual's **Social Security number** or, only if not available, the **date of birth**.

C. Enter the individual's **Medicaid number (RID)**, if appropriate.

D. Record the **home, hospital or NF address** which reflects the current location of the individual. Include the name of the hospital or NF, if appropriate.

Section 2: CMHC Name and Address

A. Enter the **name of the CMHC**.

B. At a minimum, record the city in which the main office of the CMHC is located.

Section 3: Purpose of Referral

A. **If PAS,** check the box labeled PAS and send the completed form to the originating / local IPAS agency.

B. **If ARR,** check the box labeled ARR. Differentiate whether the referral is a "routine" or "non-routine" ARR. Send the completed form with other documentation to the PASARR / MI program.

Section 4: Reason for Decision

A. On the first blank line, enter the **date the referral was received** by the CMHC from the IPAS agency or the NF.

B. Check the applicable box(es) which states the **reason** the referral for a Level II was inappropriate.

C. Write **additional information**, if applicable, in the spaces provided.

Section 5: CMHC Certification

The CMHC PASARR reviewer (*a qualified mental health professional*) must **sign** and **date** the form, with a **telephone number** and specifying his / her **title / credentials**.

PASARR / MI SPECIALIZED SERVICES ALTERNATIVE DOCUMENTATION FOR NURSING FACILITY RESIDENTS

State Form 47181 (1-97) / BAIS 0033

HH-1

Name of resident
Name of facility
Address of facility (*number and street, city, state, ZIP code*)

I. ☐ 1. Individual qualifies for MI specialized services alternative. (*See back for definition.*)
☐ 2. Individual does not qualify for MI specialized services alternative.

ACTIVITIES	DATE(S)
II. Individual has: ☐ 3. had conversation / contact with alternatives presenter.	
☐ 4. had alternatives explained and offered.	
☐ 5. refused to participate / cooperate.	
Family, Guardian, Personal Representative has: ☐ 6. had conversation / contact with alternatives presenter.	
☐ 7. had alternatives explained and offered.	
☐ 8. refused to participate / cooperate.	

III. ☐ 9. Individual ☐ is ☐ is not his / her own guardian.

☐ 10. Individual ☐ can ☐ cannot make an informed decision.

☐ 11. Individual exercises his alternative
- ☐ a. decline MI specialized services and be discharged from the nursing facility;
- ☐ b. agree to receive MI specialized services in appropriate placement in:
  - ☐ 1. an inpatient psychiatric unit;
  - ☐ 2. a state operated psychiatric unit;
  - ☐ 3. a nursing facility (*if equivalent psychiatric care is provided*); or
  - ☐ 4. other:

IV. To be completed after the specialized services alternative is presented:

☐ I understand that after I am discharged from the nursing facility to an alternative placement, I cannot be readmitted to a Medicaid-certified nursing facility and Medicaid will not pay for services in a nursing facility unless my medical needs warrant return to the nursing facility **AND** I no longer need specialized services.

☐ Family/guardian/personal representative understands that after the individual is discharged from the nursing facility to an alternative placement, the individual cannot be readmitted to a Medicaid-certified nursing facility and Medicaid will not pay for services in a nursing facility unless the individual's medical needs warrant return to the nursing facility **AND** the individual no longer needs specialized services.

V. Signature of individual	Date (*month, day, year*)
Signature of family / guardian / personal representative (*circle one*)	Date (*month, day, year*)
Signature of alternatives presenter	Date (*month, day, year*)

Original: PASARR / MI Alternatives Presenter
Copy: Resident / Guardian / Legal Representative
Copy: PASARR / MI Program, DDARS / BAIHS, 402 W. Washington Street, Room W454, Box 7083, Indianapolis, Indiana 46207-7083

PASARR / MI SPECIALIZED SERVICES ALTERNATIVES DOCUMENTATION FOR NURSING FACILITY RESIDENTS

The purpose of the PASARR / MI Specialized Services Alternatives Documentation is to:

1. Identify nursing facility residents who must be offered available alternative settings in which to receive MI specialized services under Section 1919 (e) (7) (c) of Federal Public Law 100-203 (OBRA '87);
2. Provide information to assist residents and their families, guardians, or legal representatives to understand requirements, possible alternatives, and the consequences of discharge from the nursing facility; and
3. Document how, when, and by whom the placements options available to the resident were explained and the resident's choice.

Directions for completing the form:

Enter the resident's name, facility name, and location at the top of the form.

Section I (*Items 1 - 2*) identifies whether the resident has met the criteria for the alternatives option under Federal Public Law 100-203 (OBRA '87). Check only one (1).

Section II (*Items 3 - 8*) documents the activities that provide information on available alternatives. Items 5 and 8 assure the right of residents and legal representatives NOT to participate, if that is their choice, and to be discharged from the nursing facility. Where there are differences of opinion between residents and their legal representatives, a referral should be made to Indiana Advocacy Services by the alternatives presenter to assure that the individual's rights are protected. Check as many boxes as are appropriate. Fill in a date for each item checked.

Section III (*Items 9 - 11*) documents the decision and who is making it.

Section IV ***MUST*** be completed when a resident is presented with the MI specialized services alternatives option.

Section V should have at least two (2) signatures. When the resident with an MI condition has not been determined to be incompetent, the resident must sign the form. When a resident has a legal guardian, the signature of the guardian must be included. In this situation, the resident may also sign the form. The alternatives presenter must always sign. The date each entity signs the form must be entered.

*This completed form **must** be submitted to the State PASARR Unit for the process to be completed. A copy must be forwarded to the appropriate CMHC, and a copy should be maintained in the resident's file which is kept by the alternatives presenter.*

DEFINITION OF "MI SPECIALIZED SERVICES": Specialized Services are defined as the implementation of an individualized plan of care developed under and supervised by a physician, provided by a physician and other qualified mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of severe mental illness, which necessitates supervision by trained MH personnel. A nursing facility resident with mental illness who requires specialized services shall be considered to be eligible for the level of services provided in an institution for mental diseases (IMD) or an inpatient psychiatric hospital (*subject to Medicaid reimbursement requirements*).

PRE-ADMISSION SCREENING / RESIDENT REVIEW CERTIFICATION FOR NURSING FACILITY SERVICES

State Form 46922 (R / 2-98) / BAIS 0024

JJ

1. Name of applicant / resident			2. Medicaid number
3. Social Security number	4.Sex	5. Date of birth *(month, day, year)*	6. Age
7. Name of facility			
Address of facility *(number, street, city, state, ZIP code)*			
8. Date of admission *(month, day, year)*		9. Method of payment ☐ Medicaid Funding ☐ Medicaid Pending ☐ Private Pay	

LEVEL I

The applicant / resident was referred as having a:

10. Date received Level II *(month, day, year)*

11. ☐ Developmental disability; or
12. ☐ Developmental disability and a mental illness.

LEVEL II

The applicant / resident:

13. ☐ Has a developmental disability;
14. ☐ Has a developmental disability and a mental illness;
15. ☐ Does **NOT** have a developmental disability.
16. ☐ Determination deferred.
17. ☐ Requires resident review in one year.

The applicant / resident:

18. ☐ Requires Specialized Services for a developmental disability;
    18a. Provided by: _____
19. ☐ Requires Specialized Rehabilitation Services for a developmental disability;
20. ☐ Has medical needs that take precedence over other service needs;
    20a. ☐ Short term - Length of stay _____
    20b. ☐ Long term
21. ☐ Requires **NO** additional services for a developmental disability.

Nursing facility services:

22. The applicant/resident ☐ does ☐ does not meet PASRR Level II criteria for:
23. ☐ Admission to a nursing facility;
24. ☐ Continued residence in a nursing facility.

Criteria:

25. ☐ Exempted hospital discharge;
26. ☐ APS admission;
27. ☐ Respite admission;
28. ☐ Nursing services for medical needs; *(see attachments)*
29. ☐ Geriatric medical issues;
30. ☐ Resident alternative;
31. ☐ None of the above criteria apply.

Signature of IDDARS PASRR representative	Title of IDDARS PASRR representative
Telephone number ( )	Date of certification *(month, day, year)*

C: DDFS File; AAA; Consumer / Guardian / HCR; Nursing Facility; BAIHS; D & E Team

needed services. Even when planning is available, patients sometimes defer or avoid recommended referrals or follow-up care.

The other provisions of this rule will have no significant effect.

We have determined and the Secretary certifies that this final rule will not have a significant economic impact on a substantial number of small entities. We have therefore not prepared a regulatory flexibility analysis.

Section 1102(b) of the Social Security Act requires the Secretary to prepare a regulatory impact analysis if a final rule may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

We are not preparing a rural impact statement since we have determined, and the Secretary certifies, that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this regulation was not reviewed by the Office of Management and Budget.

VIII. Paperwork Reduction Act

Section 482.43 of this rule contains information collection requirements that are subject to the Office of Management and Budget (OMB) approval under the Paperwork Reduction Act of 1980 (44 U.S.C. 3504, *et seq.*). The reporting burden for the collections of information in § 482.43 is comparable to the burden for § 482.21(b), which it replaces (and which is currently approved under OMB approval number 0938–0328).

IX. Waiver of Proposed Rulemaking

The Administrative Procedure Act (5 U.S.C. 553) requires us to publish a general notice of proposed rulemaking in the **Federal Register** and afford prior public comment on proposed rules. Such notice includes a statement of the time, place and nature of rulemaking proceedings, reference to the legal authority under which the rule is proposed rule or a description of the subjects and issues involved. However, this requirement does not apply when the agency finds good cause that such a notice and comment procedure is impracticable, unnecessary, or contrary to the public interest, and incorporates its reasons in the rules issued.

We have in this final rule published our intent to conform our requirements on medical director qualifications to those of section 6025 of Public Law 101–239 and to change the name of an accrediting program. Since this final rule merely conforms our regulations regarding medical director qualifications to the statute without interpretation, and the change of name of an accrediting program only amends the regulations to reflect the new name, we believe it to be unnecessary and not in the public interest to publish a proposed rule to obtain public comment.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 482

Administrative practice and procedure, Certification of compliance, Contracts (Agreements), Health care, Health facilities, Health professions, Hospitals, Laboratories, Medicare, Onsite surveys, Outpatient providers, Reporting requirements, Rural areas, X-rays.

42 CFR Chapter IV is amended as set forth below:

A. Part 405, subpart N, is amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

1. The authority citation for subpart N continues to read as follows.

Authority: Secs. 1102, 1861(s)(3), (11) and (12), 1864, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(s)(3), (11), and (12), 1395aa and 1395hh).

Subpart N—Conditions for Coverage of Portable X-ray Services

§ 405.1413 [Amended]

2. Section 405.1413(a)(1) is amended by revising the name of "the Council on Education" to "the Committee on Allied Health Education and Accreditation."

B. Part 482 is amended as follows:

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

1. The authority citation for part 482 continues to read as follows:

Authority: Secs. 1102, 1136, 1138, 1814(a)(6), 1861 (e), (f), (r), (v)(1)(G), (z), and (ee), 1864, 1871, 1883, 1886, 1902(a)(30), and 1905(a) of the Social Security Act (42 U.S.C. 1302, 1320b–6, 1338, 1395f(a)(6), 1395x (e), (f), (k), (r), (v)(1)(G), (z), and (ee), 1395aa, 1395hh, 1395tt, 1395ww, 1396a(a)(30), and 1396(a)).

2. Section 482.21(b) is revised as follows:

§ 482.21 Condition of participation: Quality assurance.

* * * * *

(b) *Standard: Medically-related patient care services* The hospital must have an ongoing plan, consistent with available community and hospital resources, to provide or make available social work, psychological, and educational services to meet the medically-related needs of its patients.

3. In § 482.22(b), the introductory text is republished and paragraph (b)(3) is revised to read as follows:

§ 482.22 Conditions of participation: Medical staff.

* * * * *

(b) *Standard: Medical staff organization and accountability.* The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to patients.

* * * * *

(3) The responsibility for organization and conduct of the medical staff must be assigned only to an individual doctor of medicine or osteopathy or, when permitted by State law of the State in which the hospital is located, a doctor of dental surgery or dental medicine.

4. A new § 482.43 is added as follows.

§ 482.43 Condition of participation: Discharge planning.

The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing.

(a) *Standard: Identification of patients in need of discharge planning* The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.

(b) *Standard: Discharge planning evaluation.*

(1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.

(2) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.

(3) The discharge planning evaluation must include an evaluation of the

likelihood of a patient needing post-hospital services and of the availability of the services.

(4) The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.

(5) The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.

(6) The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and must discuss the results of the evaluation with the patient or individual acting on his or her behalf.

(c) *Standard: Discharge plan.*

(1) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan.

(2) In the absence of a finding by the hospital that a patient needs a discharge plan, the patient's physician may request a discharge plan. In such a case, the hospital must develop a discharge plan for the patient.

(3) The hospital must arrange for the initial implementation of the patient's discharge plan.

(4) The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

(5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.

(d) *Standard: Transfer or referral.* The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for followup or ancillary care.

(e) *Standard: Reassessment.* The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.

(Catalog of Federal Domestic Assistance Programs No. 93 778, Medical Assistance Program, No. 93 773, Medicare—Hospital Insurance Program: No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 23, 1994.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration

Approved: December 5, 1994

Donna E. Shalala,

Secretary.

[FR Doc 94-30555 Filed 12-12-94, 8:45 am]

BILLING CODE 4120-01-P

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42 CFR Parts 412 and 413

[BPD-802-CN]

RIN 0938-AG46

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1995 Rates; Correction

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule; correction.

SUMMARY: In the September 1, 1994 issue of the **Federal Register** (59 FR 45330), we published a final rule with comment period revising the Medicare hospital inpatient prospective payment systems for operating costs and capital-related costs to implement necessary changes arising from our continuing experience with the system. In the addendum to that final rule with comment period, we announced the prospective payment rates for Medicare hospital inpatient services for operating costs and capital-related costs applicable to discharges occurring on or after October 1, 1994, and set forth update factors for the rate-of-increase limits for hospitals and hospital units excluded from the prospective payment systems. This notice corrects errors made in that document.

EFFECTIVE DATE: October 1, 1994

FOR FURTHER INFORMATION CONTACT: John Davis—Wage Index (410) 966-5654, Nancy Edwards—Other Issues (410) 966-4531.

SUPPLEMENTARY INFORMATION: In the September 1, 1994 final rule with comment period (59 FR 45330), we indicated that if a hospital believes its wage index value is incorrect as a result of an intermediary or HCFA error, the hospital must notify HCFA no later than September 23, 1994. As a result of this process, we have identified several corrections to the wage data. Accordingly, the wage index values for several areas have been changed.

The final rule also contained other technical and typographical errors. The revised wage index values, and other changes affecting prospective payment rates, reflect corrections that were made between publication of the FY 1995 prospective payment system final rule with comment period on September 1, 1994, and implementation of the FY 1995 prospective payment rates on October 1, 1994. Therefore, we are making the following corrections to the September 1, 1994 final rule with comment period:

1. On page 45361, the chart at the top of the page is corrected as follows:

Percentage change in area wage index value	Number of labor market areas		Corrected number of labor market areas	
	FY 1995	FY 1994	FY 1995	FY 1994
Increase more than 10 percent	2	13	5	13
Increase between 5 and 10 percent	4	24	17	24
Decrease between 5 and 10 percent	13	58	13	58
Decrease more than 10 percent	10	14	10	14

2. On pages 45421 through 45436, the following entries in Table 3C—Hospital Case Mix Indexes for Discharges Occurring in Federal Fiscal Year 1993; Hospital Average Hourly Wage for Federal Fiscal Year 1995 Wage Index—are corrected as follows:

Provider	Case mix index	Avg. hour wage	Corrected avg. hour wage
050030	01.3478	17.25	17.31
050153	01.6323	26.54	26.63
050183	01.1897	18.72	19.77

INDIANA PAS/PASRR PROGRAM
FAX COVER SHEET

State Form 47178 (R2 / 8-98) / BAIS 0025

Transmit to FAXNET number:
State PASRR Unit: (317)233-2182 or (317)233-9135
OMPP: (317)233-8379

CONFIDENTIALITY NOTICE

The documents accompanying this telecopy transmission may contain confidential information. The information is intended only for use by the individual(s) or company named above. If you are not the intended recipient, you are notified that any disclosure, copying, distribution, or the taking of any action in reliance on the contents of this telecopied information is not permissible. If you have received this telecopy in error, please immediately notify us by telephone at the number below* to arrange for the return of the original documents. Thank you.

Date (*month, day, year*):	Time: ☐ AM ☐ PM	Total number of pages (*including this sheet*):
TO:	FROM: (*name of person to contact*)	*Telephone number ( )

☐ **PASRR Program:**
FAMILY AND SOCIAL SERVICES ADMINISTRATION
Bureau of Aging and In-Home Services
402 W. Washington St., W454
P.O. Box 7083
Indianapolis, IN 46207-7083

☐ **IPAS Only:**
FAMILY AND SOCIAL SERVICES ADMINISTRATION
Office of Medicaid Policy and Planning
402 W. Washington St., W382
Indianapolis, IN 46204

Agency / Hospital (*name, city*)

Case name:

☐ **ALTERNATE FAX NUMBER:** Enter FAX number to which determination form(s) should be faxed if different from FAX number at main office: ( )

Check one:
☐ MI ☐ MR / DD or MI / MR / DD ☐ IPAS (*non-PASRR*)

Check one:
☐ PAS ☐ PAS - Rescreening ☐ *Significant - Change RR only*

☐ RESIDENT
- ☐ At Home
- ☐ In Hospital
- ☐ In NF
- ☐ APS Admission
- ☐ Extension of PASRR Exempted Hospital Discharge
- ☐ Other: _____

☐ NONRESIDENT
- ☐ Indiana hospital patient
- ☐ Out-of-State hospital
- ☐ At Home
- ☐ Out-of-State NF
- ☐ Indiana NF (*Hospital Direct after treatment in ER **and** acute care bed*)
- ☐ Other_____

NOTE: Do not send in original or hard copy unless requested.

☐ Please call this office to review this material:

☐ As you requested:

☐ Comments:

Signature of IPAS agency, CMHC or BDDS Ofc. representative completing this form	Identify: IPAS Agency number, BDDS Ofc., or CMHC	Date (*month, day, year*)

☐ This packet was received at the State PASRR Unit.
☐ This packet was received at OMPP.

Signature of representative of State PASRR Unit / OMPP

If a verbal determination is received, complete the information below as indicated:

☐ **VERBAL APPROVAL** ☐ **VERBAL DENIAL**

Approved or denied by: (*Name of State PASRR Specialist or Medicaid LOC Reviewer*)	Date approved or denied (*month, day, year*)	Short-Term Approval: Enter number of days

PRE-ADMISSION SCREENING / RESIDENT REVIEW
CERTIFICATION FOR NURSING FACILITY SERVICES

Directions for completion:

* Form is to be completed by PASRR representative in BDDS District Office.

* Statements numbered 1 through 9 require identifying information regarding the individual. In most cases, the information will be generated when the Level II is completed. Review for accuracy. The Date of Admission should note the date the individual was first admitted to a nursing facility if the individual has not been discharged except for hospitalizations. **Check all for accuracy.**

* Statement 10 is for logging purposes. For all cases, this is the date the Level II is received at the BDDS District Office from the D & E team. For those persons requiring a case conference, the conference is to occur within 30 days of the receipt of the Level II.

* Either number 11 **OR** number 12 must be marked. Use Level II to complete. Check for accuracy.

* When number 15 or 16 is marked, **DO NOT** mark any of the items numbered 18 through 31. Mark 17 **IF** number 16 is marked and a RR is required in one year, sign and date.

* Do not mark number 17 if number 15 is marked.

* For RRs, when 18 is marked, 18a. must be completed.

* When number 20 is marked on PAS cases, mark 20a. for short term and specify length of time recommended (*example: 30, 60, 90, 120 days*) or long term for no end date.

* With number 28 (Nursing Services for Medical Needs) and number 29 (Geriatric Medical Issues) number 20 (Has Medical Needs is marked.

* There may be cases where with number 28, number 19 (Requires Specialized Rehabilitation Services for a developmental disability) **AND** number 20 (Has Medical Needs) are both marked.

* With number 25 (Exempted Hospital Discharge), number 26 (APS Admission) or number 27 (Respite Admission) or number 21 (Requires NO additional services for a developmental disability) is marked.

* If number 28 (Nursing Services for Medical Needs) is marked, for PAS cases that information must be in the attached Level II submitted. For RRs the information may be attached or summarized on the form.

* The **Exempted Hospital Discharge, APS Admission and Respite Admission** must originate with and be signed by the local PAS agency. They are used only for PAS cases.

* Information on the CERTIFICATION FORM should be consistent with the Level II packet and services recommended. If it is not, an addendum **IS REQUIRED.**

KK

DEFINITION OF SPECIALIZED SERVICES FOR PAS/ARR

State Form 46921 (3-95) BAIS 0023

Name of applicant / resident	
Name of facility	
Name of OBRA service coordinator	Date *(month, day, year)*

As defined in the Indiana State Plan Amendment 1-1-93 under Title XIX of the Social Security Act, "specialized services are those services identified through the Level II Assessment which are required to address the identified needs related to the person's developmental disability and/or mental illness. These services are not typically provided within or by a nursing facility due to the duration and/or intensity of the services. Specialized services include, but are not limited to, short-term inpatient psychiatric care, long-term inpatient psychiatric care, supported employment, supported employment follow along, sheltered work, vocational evaluation, work adjustment training, vocational skills training and job placement." Specialized Rehabilitative Services are those services identified through the Level II assessment which are required to address one's identified needs as a result of their developmental disability and/or mental illness. These services are less intensive than "Specialized Services" and can be provided in a nursing facility or under contract with outside sources. For persons with a developmental disability the following service options should be considered as specialized services, specialized rehabilitative services, or both, and the appropriate services checked by the OBRA Service Coordinator.

SRS	SS	PROGRAM / SERVICE
☐	☐	Habilitation Training
	☐	Sheltered Work
	☐	Vocational Evaluation
	☐	Work Adjustment
	☐	Vocational Skills Training
☐	☐	Personal Adjustment for Blind
☐	☐	Senior Citizens Program
	☐	Job Development / Placement
	☐	Supported Employment
	☐	Other VR Ancillary Services *(specify)* _____
		_____
☐	☐	Other *(specify)* _____
		_____
		_____

☐	☐	Occupational Therapy
☐	☐	Physical Therapy
☐	☐	Speech / Language Therapy
☐	☐	Behavior Management
☐		Mental Health Services
☐		Advocate / Guardian
☐		Recreation / Leisure
☐	☐	Additional Evaluations or Exams (specify) _____
		_____

INDIANA'S

PreAdmission Screening (IPAS) Program

(IPAS-INFO 1/96)

Indiana's Nursing Facility PreAdmission Screening (IPAS) program can help you evaluate your situation and provide information on possible alternatives to admission to a nursing facility (NF).

Indiana's PAS program started in 1983. It's primary purpose is to assure that, before an individual is placed in a NF, alternatives (in-home and community services) have been explored.

The State Legislature was also concerned about rising Medicaid costs for NF care and the increasing number of elderly people. The IPAS program monitors NF admissions to insure that placements are appropriate. Individuals are helped to stay at home by finding and assisting them to access in-home and community services that are necessary to avoid or delay NF placement. Nursing facility beds are then available for those who need them most.

WHAT IS PRE-ADMISSION SCREENING (PAS)?

IPAS is a process which consists of an application, a comprehensive assessment of needs, a plan of care, and a finding or decision concerning the most appropriate placement for an individual.

The application will initiate an appointment with the case manager member of the IPAS team. Your doctor is also a member of the team.

The case manager will meet with you and your family to discuss your medical problems, how much help you need with activities of daily living, and the kind of help you may receive in your home. Based on the assessment and knowledge of alternative services available in your area, the IPAS team recommends either NF care or continued living at home. The final determination for an individual eligible for Medicaid is made by a professional team at the Office of Medicaid Policy and Planning.

DO I HAVE TO PARTICIPATE IN IPAS?

By state law, *ALL* persons, regardless of income or resources, must participate in IPAS to be admitted to a NF in Indiana. You may choose to agree or refuse to participate. However, if you refuse and are admitted to a NF, you will incur a penalty of non-payment by Medicaid of per diem costs for up to one (1) year.

It is the responsibility of every NF in Indiana to inform each individual seeking admission that there is an IPAS program, what it is, and the penalty for non-participation.

HOW DO I APPLY FOR IPAS?

Application is usually made through the NF to which you are seeking admission. It may also be made at a hospital in which you are a patient or at your local Area Agency on Aging.

The NF must assure that the IPAS application is immediately sent to the IPAS agency. A NF which admits an individual without following IPAS program requirements commits a Class A infraction. Federal law also requires the NF to provide answers to a series of questions called a Level I screen. The answers to these questions will indicate whether a specialized assessment (Level II) should be done to identify additional services you may need for a

condition of mental illness or developmental disability.

HOW LONG DOES THE IPAS DECISION TAKE?

The time limit for the IPAS process varies according to the situation. It should be completed within the following time frames:

- **At home:** As soon as possible, but no later than 25 days
- **In the nursing facility:** Within the time limits specified under the designee authorization for admission
- **Emergency/APS:** Within 25 days from the date of admission
- **Short-Term (30-Day):** If discharged within the 30-day limit, no assessment is completed. If longer stay is needed, complete assessment within an additional 25 days
- **Direct-from-Hospital:** Doctor's estimated recovery time (ERT) plus 25 days, not to exceed 120 days (Medicaid eligibles limited to 25 days)

When Level II assessment is needed, a determination should be made within 7-9 working days.

When IPAS assessment is completed, you will receive the decision on a PAS Form 4B.

MUST I ENTER A NURSING FACILITY IF IPAS FINDS THAT PLACEMENT IS APPROPRIATE?

No. The IPAS finding that placement is appropriate means that you have needs which NF care is designed to meet and that community support services to meet those needs were not available.

You may always choose to use services which have been identified and remain at home or in the community.

However, if you enter a NF after an IPAS finding that placement is *NOT* appropriate, you will incur the penalty of non-payment of per diem by Medicaid for up to one year from the date of admission.

WHAT IF THE IPAS SCREENING IS NOT COMPLETED ON TIME?

If everyone (including your doctor, the NF and others as appropriate) cooperated promptly to provide necessary information, but the IPAS decision was not rendered in time, you may request a waiver of the IPAS penalty from the State. If the waiver is granted, you may enter the NF without incurring the IPAS penalty. Contact your local IPAS agency for information and assistance. *NOTE: If Medicaid per diem is needed, all other Medicaid eligibility requirements still apply.*

If you seek Medicaid for your NF care, you will need to provide information to OMPP concerning your IPAS participation status.

WHAT IF I DO NOT AGREE WITH THE IPAS FINDING?

You may appeal any decision if you do not agree. Directions on how to appeal are printed on the back of the IPAS determination form (PAS Form 4B) which you will receive.

CONTACT YOUR LOCAL AREA AGENCY ON AGING (IPAS AGENCY) TO RECEIVE ASSISTANCE AND ANSWER ANY QUESTIONS.

APPLICATION FOR LONG-TERM CARE SERVICES

State Form 45943 (R6 / 7-99) / BAIS 0018

PLEASE COMPLETE BOTH SIDES OF THIS FORM.

*THIS STATE AGENCY IS REQUIRING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER PER IC 4-1-8-1. THE INFORMATION OBTAINED ON THIS FORM IS CONFIDENTIAL UNDER STATE AND FEDERAL REGULATIONS. THIS INFORMATION WILL NOT BE RELEASED EXCEPT AS PERMITTED OR REQUIRED BY LAW OR WITH THE CONSENT OF THE APPLICANT.

Application is for (*check one*):
☐ Indiana's PreAdmission Screening (IPAS) / PreAdmission Screening and Resident Review (PASRR) ☐ In-Home Services

Initiated by:

If In-Home Services, check all that apply: ☐ C.H.O.I.C.E. ☐ S.S.B.G. ☐ Title III In-Home Services
☐ A & D Waiver ☐ Autism Waiver ☐ ICF / MR Waiver ☐ Medically Fragile Children's Waiver ☐ TBI Waiver

SECTION I - To be completed by the applicant, guardian, or responsible person.

Name of applicant

Telephone number ( )

*Social Security number

Home address (*number and street, apartment number, R.R. number, city, state and ZIP code*)

State of residence prior to NF placement:
☐ INDIANA ☐ OTHER _____

Date of birth:

☐ Male ☐ Female

Age:

Reason why out-of-state resident is requesting admission to an Indiana nursing facility:
☐ No bed available in home state
☐ Family is moving to or resides in Indiana, etc.
☐ Other _____

Medicaid status: (*check all that apply*) State: _____
☐ a. Medicaid applicant county number: _____
☐ b. Medicaid recipient number: _____
☐ c. Will apply for Medicaid ☐ At admission or within ☐ 30 ☐ 60 ☐ 90 ☐ 120 days
☐ d. Non-Medicaid / Private-pay for at least 6 months after admission
☐ e. Medicaid Waiver Services recipient ☐ Yes ☐ No
☐ f. Medicaid MCO Enrollee ☐ Medicaid effective date: _____

Marital status:
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Applicant's location at time of application:
☐ a. Home b. Hospital ☐ c. CMHC ☐ d. Nursing Facility
☐ In-state
☐ Out-of-state
☐ e. Other _____
Address: _____

Name of relative or contact person / address

Telephone number ( )

Name of physician / address

Telephone number ( )

PREADMISSION SCREENING NOTIFICATION

Every person applying for admission to a nursing facility in Indiana must be assessed by the PreAdmission Screening Program (PAS) to determine the person's need for care in a nursing facility. Failure to participate in the PreAdmission Screening Program will result in the applicant's ineligibility for Medicaid reimbursement in any nursing facility for up to one (1) year from date of admission. **NOTE: See IPAS Information Sheet for program details.**

☐ **I AGREE** to participate in the PreAdmission Screening Program to determine my need for care in a nursing facility and / or home and community-based services.

I AUTHORIZE THE RELEASE OF INFORMATION to and among state agencies and their agents on my medical condition and other relevant information necessary to determine appropriate long-term care services and / or In-Home Services, by my physician, hospital, nursing facility, Community Mental Health Center, Division of Mental Health, Office of Family and Children, other social service or health services providers, and family members. I understand I may revoke this release of information in writing at any time.

☐ **I DO NOT AGREE** to participate in the PreAdmission Screening Program and I understand that I will not be eligible for Medicaid reimbursement in any nursing facility for up to one (1) year from date of admission.

Signature of applicant or responsible person

Date

If signature is by a responsible person, what is the relationship to the applicant?

Signature of witness (*Required if the signature is by an "X"*)

Date

SECTION II - Temporary Admission Authorization - To be completed by PAS agency designee or discharge planner designee.

I authorize temporary admission to the nursing facility named on this application for a period of time from the date of admission to the nursing facility, as designated below. **NOTE - This authorization does not apply to PASRR Level II cases; see PASRR forms (State Form 45932 and 45277).**

Type of admission: (*Check box*)
☐ Direct from hospital (*M.D. ETR + 25 up to 120*)
☐ Emergency/APS (*25 days*)
☐ 30 Day Short Term (*30 days*)
☐ Continuing care retirement community (*30 days - extend 25 up to 55*)
☐ PASRR (*State Form 45932 or Level I required*)

Hospital Discharge Planner Designee: (*Check all that apply.*)
☐ Medicaid MCO Enrollee and NF placement for: ☐ Short-Term ☐ Long-Term
☐ I certify that this patient is a nonresident admitted to acute hospital care after treatment in the emergency room.
☐ I certify that the applicant has been given a list of long term care options that may be available to the applicant, are located within the hospital's service area, and are known to the hospital.(IC 10-12-10-28.5)

Period of care authorized: Start date: _____ Stop date: _____

Signature of (*Circle one*) IPAS agency or Discharge Planner Designee: (*For: Direct from in state acute care only*)

Date

Affiliation:

Telephone number:

FAX number:

Name of nursing facility / address (*number and street, city, state, ZIP code*)

Forms Distribution: ☐ Original - IPAS Agency ☐ Applicant ☐ Nursing Facility File ☐ CMHC ☐ BDDS ☐ OMPP ☐ State PASRR unit

Continued on the reverse side.

PAS/ARR RESIDENTIAL ALTERNATIVE DOCUMENTATION FOR NURSING FACILITY RESIDENTS

State Form 46920 (3-95) BAIS 0022

LL

Name of resident

Name of facility

☐ 1. Individual qualifies for residential alternative.

☐ 2. Individual does **not** qualify for a residential alternative.

ACTIVITIES	DATE(S)
Individual has: ☐ 3. had conversations with IFS;	
☐ 4. had conversations with residential provider's staff;	
☐ 5. visited residential options;	
☐ 6. visited day services;	
☐ 7. refused to participate in any activities.	
Family, Guardian, Advocate has:	
☐ 8. had conversations with IFS;	
☐ 9. had conversations with residential provider's staff;	
☐ 10. visited residential options;	
☐ 11. visited day programs;	
☐ 12. refused to participate in any activities.	

☐ 13. Individual ☐ is ☐ is not his/her own legal guardian.

☐ 14. Individual ☐ can ☐ cannot make an informed decision;

☐ 15. Individual exercises his/her residential alternative to:

- ☐ a. remain in a nursing facility;
- ☐ b. seek appropriate alternative residential placement in:
  - ☐ 1. supported living;
  - ☐ 2. group home;
  - ☐ 3. large ICF/MR;
  - ☐ 4. Other *(describe)* _____

To be completed if the individual exercises his/her residential alternative:

☐ I understand that once I am discharged from the nursing facility to an alternative placement, unless my medical needs warrant return to the nursing facility, Medicaid will not pay for services should I desire to return to the nursing facility.

☐ Family/guardian/advocate understands that once the individual is discharged from the nursing facility to an alternative placement, unless the individual's medical needs warrant return to the nursing facility, Medicaid will not pay for services should the individual desire to return to the nursing facility.

e of individual	Date signed *(month, day, year)*
Signature of family, guardian, advocate	Date signed *(month, day, year)*
Signature of IFS	Date signed *(month, day, year)*

RESIDENTIAL ALTERNATIVE DOCUMENTATION FOR NURSING FACILITY RESIDENTS

The purpose of the Residential Alternative Documentation is to:

1. Identify the nursing facility residents who have a residential alternative under Section 1919 (e)(7)(c) of Federal Public Law 100-203 (OBRA '87);
2. Provide tangible experiences to assist residents and their guardians, families or advocates in making an informed decision regarding alternatives; and
3. Document that the resident's rights have been protected.

Directions for completing the form:

The resident's name, facility name and facility location should be filled in at the top of the form.

Section I *(items 1-2)* identifies whether residents meet the criteria for the alternative option under Federal Public Law 100-203 (OBRA '87). Check only one (1).

Section II *(items 5-12)* suggests tangible experiences which may assist residents, guardians, families and advocates in making informed decisions regarding alternatives. Participation in as many activities as possible is encouraged to assure an informed decision. Activities in which the resident or others involved participated should be documented, including the date(s) the participation occurred. *(Items 9 and 14 are options which assure the right of residents and their families NOT to participate if that is their choice.)* Where there are differences of opinion between residents and families, a referral to Indiana Advocacy Services will be made by the service coordinator to assure individual rights are protected. Check as many as appropriate. A date should be filled in for each item completed.

Section III *(items 13-15)* documents the decision and who is making it.

Section IV **MUST** be complete when an individual exercises his/her residential option.

Section V should have three (3) signatures. In case of a resident with a legal guardian, the signature of the guardian and the IFS service coordinator will be accepted. It is recommended that a witness to the guardian's signature in addition to the service coordinator be added. When the nursing facility resident is a MR or MI/MR emancipated adult, there **MUST** be three signatures.

This form <u>must</u> be submitted to Medicaid for the Level of Care process to be completed. A copy should be maintained in the resident's file at the IFS office.

SECTION III - Estimated Nursing Facility Cost - To be completed by the nursing facility.		
Name of nursing facility / address (*number and street, city, state, ZIP code*)		
Name of applicant		
460 IAC 1-1-8(e), the nursing facility must provide to the IPAS agency an estimate of the cost of all services that the applicant is anticipated to require.		
level of NF services needed:		
Estimated NF cost for NF services at the rate charged to private payers: $		
Information provided by:	Telephone number:	FAX number:

PHYSICIAN CERTIFICATION FOR LONG-TERM CARE SERVICES

State Form 38143 (R5 / 6-93) Form 450B / PASARR2A

Indiana Family and Social Services Administration (IFSSA)

CONFIDENTIAL

ASSESSMENT TYPE
- ☐ Initial Assessment
- ☐ Re-Screening
- ☐ ARR

MEDICAID STATUS
- ☐ Medicaid Pending
- ☐ Medicaid Recipient
- ☐ Non-Medicaid

Name of contact	Upon completion return to: ☐ Area PAS agency ☐ IFSSA ☐ Integrated Field Services Case Manager ☐ Other _____

I - RECIPIENT IDENTIFICATION

Name of applicant *(last, first, middle)*	Date of birth *(mo., day, yr.)*	Sex	Name of county
Name of nursing facility or ICF / MR	Facility admission date *(mo., day, yr.)*		Medicaid number
Address of facility *(street and number)*	Re-admission date from hospital		Level of care transfer date
City, state and ZIP code	Requested length of care ☐ Short-term ☐ Long-term		Facility provider number(s) "I". "S".

Admitted from:
- ☐ a. Acute Hospital
- ☐ b. Psychiatric Bed
- ☐ c. Home
- ☐ d. Nursing Facility
- ☐ e. ICF/MR
- ☐ f. Out-of-state _____
- ☐ g. Other _____

II - PHYSICIAN'S MEDICAL EVALUATION

Federal and state regulations require a physician's medical evaluation, plan of treatment and explicit recommendation for care prior to admission or continued care in a nursing facility, the C.H.O.I.C.E. program, or the Medicaid Home and Community-Based Waiver program.

Patient Evaluation ***(check all applicable boxes below. "*" requires explanation in "Clinical Summary")***

- ☐ Ambulatory
- ☐ Wheelchair
- ☐ Cane or Walker
- ☐ Bedfast
- ☐ Ventilator Dependent
- ☐ Contractures
- ☐ Incontinent *(bladder)*
- ☐ Incontinent *(bowel)*
- ☐ Catheter _____
- ☐ Tracheotomy
- ☐ Colostomy / Ileostomy
- ☐ Other Ostomy
- ☐ Aphasic
- ☐ Agitated / Combative
- ☐ Confused / Disoriented
- ☐ Self Fed
- ☐ I.V. Fluids / Nutrition *
- ☐ Tube Fed - Type _____
- ☐ Decubiti *(size, stage, treatment)* *
- ☐ Other * _____

Primary diagnosis ***(include dates)***	Secondary / tertiary diagnosis ***(include dates)***

Patient's overall prognosis

Plan and Treatment ***(check all applicable boxes below. "*" requires explanation in "Clinical Summary")***

- ☐ Medications *(describe below)*
- ☐ *Restorative Services* *
- ☐ *Sterile Dressing* *
- ☐ Regular Diet
- ☐ Other (specify _____
- ☐ _____
- ☐ Minimum Nursing Intervention
- ☐ Moderate Nursing Intervention *
- ☐ Intensive Nursing Intervention *
- ☐ Independent with ADLs
- ☐ Assisted with ADLs
- ☐ Dependent for all ADLs

Medications *(dosage and frequency)*

Clinical summary *(attach additional information as necessary)*

LEVEL OF CARE PHYSICIAN CERTIFICATION

Complete for all Applications	**Complete for Home Care *(if applicable)***
Level of care recommended ☐ Skilled ☐ Intermediate ☐ ICF/MR - Large/Small ☐ Other *(specify)* _____	☐ Medicaid Home and Community Based Waiver service ☐ C.H.O.I.C.E.

I certify that community supported in-home care is ☐ safe and feasible ☐ not safe or feasible in regard to health and safety of this patient. If not safe or feasible, explain.

Signature of physician *(stamps are NOT acceptable)*	Date signed *(month, day, year)*	Typed or printed name of physician

III - STATE DEPARTMENT AUTHORIZATION

This certification is for:
☐ Admission ☐ Transfer ☐ Continued Care

☐ Approved ☐ Disapproved

Effective Medicaid reimbursement date

Comments

Authorized signature ☐ IFSSA ☐ Area PAS agency

Date signed *(month, day, year)*

Instructions for Completion of PAS Form 4A

RECOMMENDATION OF SCREENING TEAM

A. Complete "**DISTRIBUTION FOR FORM 4A SECTION**" in upper right-hand corner.
1. Enter the **PAS AGENCY NUMBER** in number 2. (*Example: #1, #2, etc.*)
2. Check the applicable box(es). (Note: Both "Medicaid recipient" and "MCO" may apply.)

B. Check the appropriate box to designate the entity to which the PAS packet should be sent.

C. Enter **MAILING NAME AND ADDRESS.**
1. Enter the **APPLICANT'S FULL NAME.**
2. Enter the **APPLICANT'S MAILING ADDRESS** to which the PAS Form 4B is to be sent. If the applicant has a guardian or person empowered to handle the applicant's affairs, that person's name should be entered with appropriate address. If copies go to more than one individual, please note.

D. Enter the **NAME AND ADDRESS OF THE NURSING FACILITY** to which the applicant has applied or in which the applicant resides under Authorized Temporary Admission Status. If a nursing facility has not been selected, enter "N/A".

E. Enter the **RECOMMENDATION OF THE SCREENING TEAM.**
1. Check (✓) the appropriate box if the Team has reached a consensus regarding the care recommendation. When appropriate, enter start and stop dates.
2. Check (✓) the appropriate box that indicates the vote of the PAS Team Coordinator when the Team members **CAN NOT** reach a consensus. When appropriate, enter start and stop dates.

F. When placement in a nursing facility is not recommended, check (✓) the appropriate box.

G. SERVICE PLAN: When placement is **NOT** appropriate because of service availability at 100% or less than the cost of nursing facility care, SUCH SERVICES **MUST BE FULLY AND ACCURATELY ENTERED.**

Refer to the Eligibility Screen - State Form 45228 to complete this section. Specify for **EACH SERVICE (*FORMAL AND INFORMAL*) THAT IS NECESSARY AND AVAILABLE:**

1. Service name
2. Service provider name and address
3. Units per month to be provided
4. Cost per month

Also use the **SERVICE PLAN** area to enter additional recommendations or information affecting the determination. For example, note IPAS penalties and time frames, Class A infractions, recommendations for short-term placement including time frames, other caveats and directions.

3. When the service plan includes a service(s) covered under the Medicaid Waiver, **ENTER AN ASTERISK (*)** to the left of **ALL** service(s) for which Medicaid will pay. Compute and enter the **MEDICAID COST ONLY FOR ALL** in-home services. (Do not include in this computation any other payment source.)

4. Enter the **NURSING FACILITY COST OF CARE PER MONTH** for all applicants who are offered a Medicaid Waivered service(s).

Optional for IPAS Agency tracking use: enter date case assigned to assessor, case completed, and date case either faxed to OMPP/State PASRR Unit or PAS Form 4B completed by IPAS agency.

5. Enter the **SIGNATURE** of the PAS Team Coordinator, the **VOTE** (*if appropriate*), and the **DATE** the PAS Form 4A was completed.

Enter the **NAME AND AGENCY** of each Team member, the **VOTE** of "yes", "no" or other, and the **DATE** on which each member's vote was obtained. (*Example: Date of physician's vote is the date on which the doctor signed PAS Form 450 B / 2A.*)

INDIANA'S PRE-ADMISSION SCREENING PROGRAM — (PAS / PASARR)

ASSESSMENT DETERMINATION

☐ PAS or ☐ PASARR

State Form 707(R3/12-93) / Form 4B

NOTE: This is a finding of need for nursing care in a nursing facility and of the availability of community services. If you need Medicaid, call your local county office, Division of Family and Children to make application.

Distribution for Form 4B

1. Original: Applicant
2. Copy: PAS agency #_____
3. Copy and Packet: Nursing Facility
4. ☐ Medicaid pending
   ☐ Medicaid recipient
   ☐ Private-pay

P

TO:

RE: Applicant Name: (please print)

Applicant Mailing Address:

This notice will advise you of the decision concerning your application for admission to a nursing facility in the state of Indiana. It is based on a comprehensive assessment by the PAS Screening Team serving your area (Indiana Code 12-10-12) and PASARR (42 CFR 483.106 and 483.112).

☐ You may ☐ enter ☐ not enter ☐ remain ☐ not remain in the nursing facility without being subject to potential future penalty concerning payment per diem in the nursing facility.

☐ Your Pre-Admission Screening Assessment was not completed due to _____

Based on the medical and social information submitted and a review of the available alternative community services and resources, your placement in a nursing facility is found to be:

☐ **APPROPRIATE** If you have not yet entered a nursing facility, this approval will be effective for ninety (90) days from the date of this notice.
Note: A PAS finding that nursing facility placement is appropriate does **not** mean that you must enter a nursing facility or remain there. You always have the choice to remain in your home and use any services identified during the PAS assessment.

☐ **INAPPROPRIATE** Because, you do not have medical needs that meet the State criteria for approval of nursing facility placement (405 IAC 1-3-2) and PASARR (42 CFR 483.118).

☐ **INAPPROPRIATE** Because, you can use the following services/resources to meet your needs:

SERVICES / RESOURCES * Denotes Medicaid covered services	PROVIDER	FREQUENCY OF USE	ESTIMATED MONTHLY COST

Nursing Facilty: (name & address)

If you disagree with the action taken on your screening, or this decision, you should discuss the matter with the staff of the Pre-Admission Screening Agency serving your area. If you are not satisfied, you may appeal and request a hearing within thirty (30) days of the date of receipt of this notice. You will find information on how to request an appeal on the back of this form.

Signature

Director or Designee: _____ Date _____

HOW TO REQUEST AN APPEAL

If you wish to appeal, send a letter with your signature to the Indiana Family and Social Services Administration, Division of Family and Children, Hearings and Appeals, 402 W. Washington Street, Room W-392, Indianapolis, Indiana 46204.

Be sure that the letter contains your address and a telephone number where you can be reached. It is also helpful if you attach a copy of this decision or state the nature of the action you are appealing. If you are unable to write this letter yourself, you may have someone assist you in requesting this appeal.

You will be notified in writing by the Division of Family and Children of the date, time, and place for the hearing. Prior to, or at the hearing, you will have the right to examine the entire contents of your case record at the PAS agency.

You may represent yourself at the hearing or authorize a representative such as an attorney, a relative, a friend, or other spokesman to do so. At the hearing you will have full opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments without interference, and question or refute any testimony or evidence presented.

Public Law 21, Acts of 1982 (IC 12-10-12) established Indiana's Health Facility PreAdmission Screening (IPAS) program, which was implemented statewide on April 30, 1983. The purpose of the PAS program is to screen each person admitted to a "health facility" (nursing facility/NF) in Indiana to assure that such placement is appropriate and that alternative community services are not available to meet the person's needs.

IC 12-10-12-3 defines a "health facility" (nursing facility/NF) as a facility that is licensed by the State Department of Health under IC 16-10-4. *ALL* nursing facilities so licensed, whether comprehensive care only or Medicare and/or Medicaid certified, are required to participate in the IPAS program.

Likewise, under IC 12-10-12 *ALL* persons admitted to an Indiana nursing facility, regardless of income or resources, Medicare or Medicaid or VA participation or private-pay status, must participate in IPAS or incur the sanction at IC 12-10-12-33 or IC 12-10-12-34.

This report is being submitted pursuant to 460 IAC 1-1-7(p) which requires that the IPAS Agency report any violation of IC 12-10-12-12 to the county prosecuting attorney.

NF Name _____

Address/City/State/Zip _____

Administrator _____ Phone _____

Applicant Name _____ SS No. or D.O.B. _____

The nursing facility (NF) named above:

☐ *Admitted the above-named person, but failed to notify him/her of PAS program requirements and to obtain a signed, completed PAS Application. [IC 12-10-12-10; 460 IAC 1-1-5]*

☐ *Properly notified the above-named person of PAS requirements, but failed to immediately forward the PAS application to the PAS agency. [IC 12-10-12-10; 460 IAC 1-1-8]*

☐ *Claims that the above-named person was notified of PAS requirements and signed and completed the PAS application, but the NF failed to retain a copy on file for one (1) year and cannot verify that timely PAS application was made. [IC 12-10-12-10; 460 IAC 1-1-8]*

_____ Date PAS Application Signed _____ NF Admission Date
_____ Date PAS Application Received at PAS agency

☐ *Admitted the above-named person prior to PAS final determination without designee authorization for temporary admission. [IC 12-10-12-5; IC 12-10-12-28, 30, 31; 460 IAC 1-1-8]*

IC 12-10-12-10 mandates certain duties for *ALL* Indiana licensed nursing facilities. FAILURE to perform certain duties constitutes a *Class A infraction under IC 12-10-12-10(d).*

IC 12-10-12-10 Notice to applicants; contents; violations
Sec. 10. (a) The notification required under section 8 of this chapter must notify the applicant of the following:
(1) That the applicant is required under state law to apply to the agency serving the county of the applicant's residence for participation in a nursing facility preadmission screening program.
(2) That the applicant's failure to participate in the nursing facility preadmission screening program could

S

NOTICE OF ACTION

State Form 46015 (R4 / 7-99) / HCBS 0005

NOTICE
See the back of this form for important information about your responsibilities and appeal rights.

☐ Aged or Disabled ☐ Autism ☐ ICF / MR ☐ Medically Fragile Children ☐ TBI

e	Medicaid number
ess	County
state, ZIP code	Mailing date of notice *(month, day, year)*

☐ NEW APPLICATION ☐ ANNUAL REDETERMINATION ☐ CHANGE / UPDATE

Indiana Family and Social Services Administration has taken the action indicated below in regard to your application for, or change ervices under the Home and Community-Based Services (HCBS) Waiver Program.

FOR APPLICATION ONLY

Effective _____, your application for services is: ☐ Approved ☐ Denied

l of Care

☐ NF / Intermediate ☐ NF / Skilled ☐ ICF / MR ☐ Hospital ☐ NF/TBI

son

Please check who approved Level of Care: ☐ State ☐ AAA

FOR ANNUAL REDETERMINATION, CHANGE / UPDATE, AND DISCONTINUANCE ONLY

E ive _____, your waiver for services are: ☐ Increased ☐ Decreased ☐ Continued at same amount ☐ Discontinued

ison

cription of change

SERVICES APPROVED

ROVIDER - SPECIFY NAME AND ADDRESS	SERVICE	START DATE	STOP DATE	TOTAL HOURS	AVE. HRS / MO.
	Case Management				

gn f case manager	Case manager's 9 digit authorization number	Date *(month, day, year)*
ddress	Case Mgr's 4 digit I.D. number	Telephone number ( )

IF YOU WISH TO APPEAL, PLEASE READ THE INFORMATION ON PAGE 2 AND THEN SIGN AND DATE BELOW.

☐ I wish to appeal the above decision.	Reason:

result in the applicant's ineligibility for Medicaid reimbursement for perdiem in any nursing facility for not more than one (1) year.

(3) That the nursing facility preadmission screening program consists of an assessment of the applicant's need for care in a nursing facility made by a team of individuals familiar with the needs of individuals seeking admission to nursing facilities.

(b) The notification must be signed by the applicant or the applicant's parent or guardian if the applicant is not competent before admission.

(c) If the applicant is admitted:

(1) the nursing facility shall retain one (1) copy of the notification for one (1) year; and

(2) the nursing facility shall deliver one (1) signed copy to the agency serving the county in which the applicant resides.

(d) A person who violates this section commits a Class A infraction.

460 IAC 1-1-8 further clarifies the responsibilities of the nursing facility relative to admissions.

460 IAC 1-1-8(d) Health facility; duties

(d) It is the responsibility of the health facility to provide verification that the application for prescreening was made prior to admission, that an individual admitted prior to the prescreening determination under IC 12-1-22-4 had designee authorization for admission required under IC 12-1-22-5.1, and that the copy of the application and other designated documentation were promptly forwarded to the prescreening agency.

Signature *Date*

Phone

R

STATEMENT FOR FREEDOM OF CHOICE

State Form 46016 (R4 / 7-99) / HCSS 0003

☐ Aged and Disabled ☐ Autism ☐ ICF / MR ☐ Medically Fragile Children ☐ TBI

icaid Waiver Services case manager has explained the array of services available to meet my needs through the Medicaid Home and unity-Based Services Waiver.

SECTION I: CHOICE BETWEEN INSTITUTIONAL PLACEMENT AND HCBS WAIVER SERVICES

TE: This section should only be completed for individuals that are choosing institutional placement. Those recipients that are choosing waiver services will sign the Freedom of Choice statement on the HCBS Plan of Care / Cost Comparison Budget form.

SERVICES AVAILABLE

☐ NF / I ☐ NF / S ☐ Hospital ☐ ICF / MR ☐ NF/TBI

I have been fully informed of the services available to me in an institutional setting. I understand the alternatives available and have been given the opportunity to choose between waiver services and institutional care.

I understand that in order to be eligible for Medicaid Waiver Services, the costs of waiver services may not exceed the costs of institutional care.

As long as I remain eligible for waiver services, I will continue to have the opportunity to choose between waiver services and institutional care.

CHOICE OF SERVICE

☐ At this time, I have chosen to receive waiver services in home and community-based settings; rather than in an institutional setting.

☐ At this time, I have chosen to receive services in an institutional setting, rather than waiver services in home and community-based settings.

SIGNATURES

ignature of recipient	Date signed *(month, day, year)*
Signature of: *(check one)* ☐ Family ☐ Guardian ☐ Witness	Date signed *(month, day, year)*
Signature of Case Manager	Date signed *(month, day, year)*

SECTION II: CHOICE BETWEEN HCBS WAIVER SERVICES AND MEDICAID MANAGED CARE

NOTE: This section should only be completed if a "Targeted" HCBS waiver applicant is currently on a Medicaid Managed Care program or if an HCBS waiver recipient wants transfer to a Medicaid Managed Care program. An individual can not be on a HCBS waiver program and a Medicaid Managed Care program.

CHOICE OF PROGRAM

(*To be completed after all eligibility determinations have been made.*)

I have been fully informed of the array of services available under the HCBS Waiver program and the Medicaid Managed Care program.

☐ At this time, I have chosen to receive HCBS Waiver services, rather than Medicaid Managed Care services.

☐ At this time, I have chosen to receive Medicaid Managed Care services, rather than HCBS Waiver services.

SIGNATURES

Signature of recipient	Date signed *(month, day, year)*
Signature of: *(check one)* ☐ Family ☐ Guardian ☐ Witness	Date signed *(month, day, year)*
Signature of Case Manager	Date signed *(month, day, year)*

PASARR CATEGORICAL DETERMINATION FOR SHORT-TERM NURSING FACILITY CARE CERTIFICATION BY PHYSICIAN FOR LONG TERM CARE SERVICES

W

State Form 45932 (5-93) Form 450B / PASARR 2A - Section V, Part B

This form is **CONFIDENTIAL** according to IC 12-15-2 *et seq.*, IC 12-10-10 *et.seq.*, IC 12-21 and 470 IAC 1-3-1.

INSTRUCTIONS: *This form **MUST** be completed prior to nursing facility admission for the following situations in accordance with 42 CFR 483.106 for persons identified as possibly being Mentally Ill (MI) or Mentally Retarded/Developmentally Disabled (MR/DD) on Section IV of the "PASARR LEVEL I" form.*

Only the PAS agency may authorize placement in a nursing facility under the conditions in Part B.

This completed form must be retained with a copy of the PAS application and PASARR Level I forms on the resident's active record in the nursing facility. A copy must be retained on file by the PAS agency with the PAS application and PASARR Level I forms. A copy of this authorization must be included in the PAS case. If longer-term placement is subsequently required, a written explanation of the change in circumstances necessitating such placement must be included with the PAS case.

Name of applicant / resident	Name of facility	City

SECTION V - PART B

1. **RESPITE SHORT-TERM (30-DAY):** An individual may be admitted to a nursing facility from home *(non-institutional setting)* for short-term respite care not to exceed thirty (30) calendar days per quarter, with a break of at least thirty (30) days between stays of fifteen (15) or more consecutive days of respite care. Respite care is a temporary or periodic service provided to a functionally impaired individual for the purpose of relieving the regular caregiver.

   At the time of admission, there must be an expressed intention of leaving the nursing facility by the expiration of the approved time period.

   NOTE: For persons with a Developmental Disability (DD) and Mental Illness (MI), the PreAdmission Screening (PAS) agency must contact the local DD Integrated Field Services Agency or Community Mental Health Center (CMHC) prior to authorization. Nursing facility (NF) placement is to be the placement of last resort.

Signature of PAS agency	Title	Date signed *(month, day, year)*	Agency number

2. **ADULT PROTECTIVE SERVICES (7-DAY):** An endangered adult who is referred to Adult Protective Services (APS) may be admitted to a nursing facility from the community for a period not to exceed seven (7) days while a determination is made and/or alternative arrangements for longer care are made. The individual must be in need of intensive emergency intervention: i.e., the individual is determined to be in imminent danger, as certified by the signature of the APS investigator.

   NOTE: For DD and MI persons, the PAS agency must immediately notify the local DD Integrated Field Services Agency or CMHC. NF placement is to be the placement of last resort.

Signature of ~~PAS~~ investigator APS	Title	Date signed *(month, day, year)*	Agency number
Signature of PAS agency	**Title**	**Date signed *(month, day, year)***	**Agency number**